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# 2004 STATE OF ILLINOIS DEPARTMENT OF PUBLIC AID FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES (FISCAL YEAR 2004)

#### IMPORTANT NOTICE

THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I.	IDPH Facility ID Number: 00	113334		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER
	Facility Name: Sacred Heart Home Inc.  Address: 1550 S. Albany Number  County: Cook	Chicago City	60623 Zip Code	I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/04 to 12/31/04 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider)
	Telephone Number: (773) 277-6868  IDPA ID Number: 362707014001	Fax # (773) 277-5014		is based on all information of which preparer has any knowledge.  Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.
	Date of Initial License for Current Owners:  Type of Ownership:  VOLUNTARY,NON-PROFIT	01/01/71  X PROPRIETARY	GOVERNMENTAL	Officer or Administrator of Provider  (Signed)
	Charitable Corp. Trust IRS Exemption Code	Individual Partnership Corporation	State County Other	(Signed) (Date)
		X "Sub-S" Corp. Limited Liability Co. Trust Other		Paid (Print Name and Title)  (Firm Name Frost, Ruttenberg & Rothblatt, P.C.
	In the event there are further questions abou Name: Steve Lavenda	t this report, please contact: Telephone Number: (847) 236	-1111	& Address) 111 Pfingsten Road, Suite 300 Deerfield, IL 60015  (Telephone) (847) 236-1111 Fax # (847) 236-1155  MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630

STATE OF ILLINOIS Page 2

H.   STATISTICAL DATA   A.   Licensurce-certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds   N/A	Facility Name & ID Numl	er Sacred Heart Home Inc.				# 0013334 Report Period Beginning: 01/01/04 Ending: 12/31/04
Committed   Comm	III. STATISTICA	L DATA				D. How many bed-hold days during this year were paid by Public Aid?
Beds at   Beginning of   Licensure   Report Period   Level of Care   Report Period   Report	A. Licensure/	certification level(s) of care; enter numb	er of beds/bed days,			None (Do not include bed-hold days in Section B.)
1   2   3   4	(must agree	with license). Date of change in licensed	beds	N/A		
1   2   3   4	, ,	,	_		_	E. List all services provided by your facility for non-patients.
Description	1	2	3	4		
Beginning of Report Period   Licensure   Report Period   Rep						, V , V , V , V , V , V , V , V , V , V
Report Period   Level of Care   Report Period   Report Perio	Beds at			Licensed		
Report Period   Level of Care   Report Period   Report Perio	Beginning of	Licensure	Beds at End of	Bed Days During		F. Does the facility maintain a daily midnight census?
1						
1						G. Do pages 3 & 4 include expenses for services or
Skilled Pediatric (SNF/PED)	1 172	Skilled (SNF)	172	62,952	1	
3		( )	1,2	02,752		'
H. Does the BALANCE SHEET (page 17) reflect any non-care assets?   Sheltered Care (SC)		,			3	
Sheltered Care (SC)		,				H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
1					5	
Totals	6	ICF/DD 16 or Less			6	
Date						I. On what date did you start providing long term care at this location?
B. Census-For the entire report period.    1	7 172	TOTALS	172	62,952	7	Date started
B. Census-For the entire report period.    1						
1						J. Was the facility purchased or leased after January 1, 1978?
Level of Care  Patient Days by Level of Care and Primary Source of Payment  Public Aid Recipient Private Pay Other Total  S SNF S 57,069 SNF/PED OTHER STORMS OTH	B. Census-For	the entire report period.				YES Date NO X
Public Aid   Private Pay   Other   Total     YES   NO   X   If YES, enter number of beds certified   and days of care provided	1	2 3	4	5		
Recipient   Private Pay   Other   Total   of beds certified   and days of care provided	Level of Care	Patient Days by Level of Care a	and Primary Source of	Payment		K. Was the facility certified for Medicare during the reporting year?
8 SNF       57,069       4       57,073       8         9 SNF/PED       9       Medicare Intermediary         10 ICF       10       11         11 ICF/DD       11       IV. ACCOUNTING BASIS         12 SC       12         13 DD 16 OR LESS       13       ACCRUAL X       CASH*		Public Aid				YES NO X If YES, enter number
9 SNF/PED         9 Medicare Intermediary           10 ICF         10           11 ICF/DD         11 IV. ACCOUNTING BASIS           12 SC         12 MODIFIED           13 DD 16 OR LESS         13 ACCRUAL X         CASH*		Recipient Private Pay	Other	Total		of beds certified and days of care provided
10   ICF	8 SNF	57,069 4		57,073	8	
11 ICF/DD         11 IV. ACCOUNTING BASIS           12 SC         12 MODIFIED           13 DD 16 OR LESS         13 ACCRUAL X         CASH*         CASH*	9 SNF/PED				9	Medicare Intermediary
12   SC	10 ICF				10	
13 DD 16 OR LESS 13 ACCRUAL X CASH* CASH*	11 ICF/DD				11	IV. ACCOUNTING BASIS
						MODIFIED
	13 DD 16 OR LESS				13	ACCRUAL X CASH* CASH*
		0.50				* * * * * * * * * * * * * * * * * * *
14 TOTALS 57,069 4 57,073 14 Is your fiscal year identical to your tax year? YES X NO	14 TOTALS	57,069 4		57,073	14	Is your fiscal year identical to your tax year? YES X NO
C. Percent Occupancy. (Column 5, line 14 divided by total licensed  Tax Year: 12/31/04  Fiscal Year: 12/31/04	C. Percent Oc	cupancy, (Column 5, line 14 divided by	total licensed			Tax Year: 12/31/04 Fiscal Year: 12/31/04
bed days on line 7, column 4.) 90.66% * All facilities other than governmental must report on the accrual basis.						
SEE ACCOUNTANTS' COMPILATION REPORT				SEE ACCOUNTAN	NTS' CO	

Facility Name & ID Number	Sacred Heart H			STATE OF ILI	LINOIS 0013334	Report Period	Beginning:	01/01/04	Ending:	Page 3 12/31/04	_
V. COST CENTER EXPENSES (through		osts Per Genera		llar)	Reclass-	Reclassified	Adjust-	Adjusted	FOR OHE	USE ONLY	$\neg$
Operating Expenses	Salary/Wage	Supplies	Other	Total	ification	Total	ments	Total	rokom	CSE OIVET	
A. General Services	1	2	3	4	5	6	7	8	9	10	
1 Dietary	230,398	24,072	57,917	312,387		312,387		312,387			1
2 Food Purchase		381,469		381,469	(38,796)	342,673	(0)	342,673			2
3 Housekeeping	292,832	50,664	13,441	356,937	* * * * * * * * * * * * * * * * * * * *	356,937		356,937			3
4 Laundry		27,797		27,797		27,797		27,797			4
5 Heat and Other Utilities			146,703	146,703		146,703	1,240	147,943			5
6 Maintenance	169,999		151,317	321,316		321,316	(37,331)	283,985			6
7 Other (specify):*											7
8 TOTAL General Services	693,229	484,002	369,378	1,546,609	(38,796)	1,507,813	(36,091)	1,471,722			8
B. Health Care and Programs	, i		ĺ				( ) /	, ,			
9 Medical Director			2,000	2,000		2,000		2,000			9
10 Nursing and Medical Records	623,866	36,047	520,446	1,180,359		1,180,359	25,800	1,206,159			10
10a Therapy											10a
11 Activities	113,193	12,596	25,323	151,112		151,112		151,112			11
12 Social Services	137,701		72,836	210,537		210,537		210,537			12
13 Nurse Aide Training											13
14 Program Transportation			665	665		665		665			14
15 Other (specify):*							6,712	6,712			15
16 TOTAL Health Care and Programs	874,760	48,643	621,270	1,544,673		1,544,673	32,512	1,577,185			16
C. General Administration		, i					, i				
17 Administrative	11,667		668,000	679,667		679,667	(509,799)	169,868			17
18 Directors Fees											18
19 Professional Services			25,819	25,819		25,819	5,643	31,462			19
20 Dues, Fees, Subscriptions & Promotions			18,099	18,099		18,099	(581)	17,518			20
21 Clerical & General Office Expenses	43,983	32,406	90,679	167,068		167,068	84,552	251,620			21
22 Employee Benefits & Payroll Taxes			203,254	203,254	38,796	242,050	(2,580)	239,470			22
23 Inservice Training & Education			İ								23
24 Travel and Seminar			758	758		758	(138)	620			24
25 Other Admin. Staff Transportation							3,362	3,362			25
26 Insurance-Prop.Liab.Malpractice			129,706	129,706		129,706	5,461	135,167			26
27 Other (specify):*					_		44,842	44,842			27
28 TOTAL General Administration	55,650	32,406	1,136,315	1,224,371	38,796	1,263,167	(369,238)	893,929			28
TOTAL Operating Expense	1,623,639	565,051	2,126,963	4,315,653		4,315,653	(372,817)	3,942,836			29
(sum of lines 8, 16 & 28)						4,313,033	ANTEL COMPH	3,942,630 ATION REPOR	т	1	29

\*\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

\*\*SEE ACCOUNTANTS' COMPILATED NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification. SEE ACCOUNTANTS' COMPILATION REPORT

#0013334

**Report Period Beginning:** 

01/0<u>1</u>/04 Ending:

Page 4 12/31/04

# V. COST CENTER EXPENSES (continued)

			Cost Per Gener	al Ledger		Reclass-	Reclassified	Adjust-	Adjusted	FOR OHF	USE ONLY	
	Capital Expense	Salary/Wage	Supplies	Other	Total	ification	Total	ments	Total			
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			90,140	90,140		90,140	5,976	96,116			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			797	797		797	19,335	20,132			32
33	Real Estate Taxes							5,927	5,927			33
34	Rent-Facility & Grounds			188,400	188,400		188,400	(188,400)				34
35	Rent-Equipment & Vehicles			7,190	7,190		7,190		7,190			35
36	Other (specify):*											36
37	TOTAL Ownership			286,527	286,527		286,527	(157,162)	129,365			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops			2,736	2,736		2,736		2,736			40
41	Coffee and Gift Shops		101,193		101,193		101,193	(78,849)	22,344			41
42	Provider Participation Fee			94,428	94,428		94,428		94,428			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		101,193	97,164	198,357		198,357	(78,849)	119,508	•		44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	1,623,639	666,244	2,510,654	4,800,537		4,800,537	(608,828)	4,191,709			45

<sup>\*</sup>Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

# 0013334

**Report Period Beginning:** 

01/01/04

12/31/04

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	1	2 Refer-	3	
	NON-ALLOWABLE EXPENSES		Amount	ence	OHF USE ONLY	
1	Day Care	\$			\$	1
2	Other Care for Outpatients					2
3	Governmental Sponsored Special Programs					3
4	Non-Patient Meals					4
5	Telephone, TV & Radio in Resident Rooms					5
6	Rented Facility Space					6
7	Sale of Supplies to Non-Patients					7
8	Laundry for Non-Patients					8
9	Non-Straightline Depreciation		1,803	30		9
10	Interest and Other Investment Income					10
11	Discounts, Allowances, Rebates & Refunds					11
12	Non-Working Officer's or Owner's Salary					12
13	Sales Tax		(0)	02		13
14	Non-Care Related Interest					14
15	Non-Care Related Owner's Transactions					15
16	Personal Expenses (Including Transportation)					16
17	Non-Care Related Fees					17
18	Fines and Penalties		(13,310)	21		18
19	Entertainment					19
20	Contributions		(250)	20		20
21	Owner or Key-Man Insurance					21
22	Special Legal Fees & Legal Retainers					22
23	Malpractice Insurance for Individuals					23
24	Bad Debt					24
25	Fund Raising, Advertising and Promotional		(1,565)	20		25
	Income Taxes and Illinois Personal					
26	Property Replacement Tax		(702)	21		26
27	Nurse Aide Training for Non-Employees		· · · · · · · · · · · · · · · · · · ·			27
28	Yellow Page Advertising		/1// 0==			28
	Other-Attach Schedule		(164,957)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$	(178,981)		\$	30

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below. (See instructions.)

2

		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)	(429,847)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (429,847)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (608,828)		37

<sup>\*</sup>These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

Yes No Amount Reference 38 Medically Necessary Transport. 38 39 39 40 Gift and Coffee Shops 40 41 Barber and Beauty Shops 41 42 Laboratory and Radiology 42 43 43 Prescription Drugs 44 Exceptional Care Program 44 45 Other-Attach Schedule 45 46 46 Other-Attach Schedule 47 TOTAL (C): (sum of lines 38-46) 47

	OHF USE ONL	Y				
48		49	50	51	52	

| Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Section | Sect NON. ALLOWABLE EXPENSES

1 Neading

2 Liscenses Husbling Company

4 PPA. Outside Office Labor

5 PPA. Paper If see

6 PPA. Outside Office Labor

7 PPA. Support If see

9 Restrict Fee

10 Aman Report Fee

11 OSOS Sension

12 PPA. Warrang Outside Labor

13 Nov. Allowable Salay

14 PPA. Outside Office Labor

16 Restrict Fee

17 PPA. Warrang Outside Labor

18 PPA. Warrang Outside Labor

19 PPA. Warrang Outside Labor

10 Aman Report Fee

11 OSOS Sension

12 PPA. Warrang Outside Labor

13 Nov. Allowable Salay

14 PPA. Warrang Outside Labor

15 PPA. Warrang Outside Labor

16 PPA. Warrang Outside Labor

17 PPA. Warrang Outside Labor

18 PPA. Warrang Outside Labor

19 PPA. Warrang Outside Labor

19 PPA. Warrang Outside Labor

10 PPA. Warrang Outside Labor

11 PPA. Warrang Outside Labor

12 PPA. Warrang Outside Labor

13 PPA. Warrang Outside Labor

14 PPA. Warrang Outside Labor

15 PPA. Warrang Outside Labor

16 PPA. Warrang Outside Labor

17 PPA. Warrang Outside Labor

18 PPA. Warrang O

STATE OF ILLINOIS

Summary A Facility Name & ID Number Sacred Heart Home Inc.

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 61 # 0013334 Report Period Beginning: 01/01/04 12/31/04 **Ending:** 

	SUMMARY OF PAGES 5, 5A, 6, 6A	1, 6B, 6C, 6D, 6	ъЕ, 6F, 6G, 6H	I AND 61										
													SUMMARY	
	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col	.7)
1	Dietary													1
2	Food Purchase	(0)											(0)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities			1,240									1,240	5
6	Maintenance	(41,086)		3,755									(37,331)	6
7	Other (specify):*													7
8	TOTAL General Services	(41,086)		4,995									(36,091)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(1,792)				27,592							25,800	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*					6,712							6,712	15
16	TOTAL Health Care and Programs	(1,792)				34,304							32,512	16
	C. General Administration													
17				(646,389)	79,436	57,154							(509,799)	17
18	Directors Fees													18
19	Professional Services	(2,736)	1,148	7,231									5,643	19
20	Fees, Subscriptions & Promotions	(2,054)	138	1,335									(581)	20
21	Clerical & General Office Expenses	(51,497)		110,343		25,706							84,552	21
22	Employee Benefits & Payroll Taxes	(2,580)											(2,580)	22
23	Inservice Training & Education			İ										23
24	Travel and Seminar	(190)		52									(138)	24
25	Other Admin. Staff Transportation			3,362									3,362	25
26	Insurance-Prop.Liab.Malpractice			5,461									5,461	26
27	Other (specify):*			25,880	11,857	7,105							44,842	27
28	TOTAL General Administration	(59,057)	1,286	(492,725)	91,293	89,965							(369,238)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(101,935)	1,286	(487,730)	91,293	124,269							(372,817)	29

STATE OF ILLINOIS

Facility Name & ID Number Sacred Heart Home Inc.

STATE OF ILLINOIS Summary B 0013334 Report Period Beginning: 01/01/04 Ending: 12/31/04

# SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

													SUMMARY	
	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.	.7)
30	Depreciation	1,803		4,173									5,976	30
31	Amortization of Pre-Op. & Org.													31
32	Interest			19,335									19,335	32
33	Real Estate Taxes		2,892	3,035									5,927	33
34	Rent-Facility & Grounds		(188,400)										(188,400)	34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*													36
37	TOTAL Ownership	1,803	(185,508)	26,543									(157,162)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops	(78,849)											(78,849)	41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	TOTAL Special Cost Centers	(78,849)											(78,849)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(178,981)	(184,222)	(461,187)	91,293	124,269							(608,828)	45

# 0013334

Report Period Beginning:

01/01/04 En

**Ending:** 

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# VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

A. Effici below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessar								
1		2		3				
OWNERS		RELATED NURSING HOME	OTHER REL	OTHER RELATED BUSINESS ENTITIES				
Name	Ownership %	Name	City	Name	City	Type of Business		
Peter O'Brien	60.00%	See Attached		See Attached				
Daniel O'Brien	20.00%							
Mary O'Brien	20.00%							

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

X YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with

the instructions for determining costs as specified for this form.

	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
						Percent	Operating Cost	Adjustments for	
Sche	edule V	Line	Item	Amount	Name of Related Organization	of	of Related	Related Organization	
						Ownership	Organization	Costs (7 minus 4)	
1	V		Rent	\$ 188,400	Long Term Care LP		\$	\$ (188,400)	1
2	V	33	Real Estate Taxes		Long Term Care LP		2,892	2,892	2
3	V	20	Licenses and Fees		Long Term Care LP		138	138	3
4	V	19	Professional Fees		Long Term Care LP		1,148	1,148	4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 188,400			\$ 4,178	\$ * (184,222)	14

<sup>\*</sup> Total must agree with the amount recorded on line 34 of Schedule VI.

# VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, X YES NO management fees, purchase of supplies, and so forth.

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with

the instructions for determining costs as specified for this form.

	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
						Percent	Operating Cost	Adjustments for	
Scho	edule V	Line	Item	Amount	Name of Related Organization	of	of Related	Related Organization	
						Ownership	Organization	Costs (7 minus 4)	
15	V	5	UTILITIES	S	MADO MGMT, LP	100.00%			15
16	V	6	REPAIRS AND MAINT.		MADO MGMT, LP		3,755	3,755	16
17	V	17	ADMINISTRATIVE		MADO MGMT, LP		21,611	21,611	17
18	V	19	PROFESSIONAL FEES		MADO MGMT, LP		7,231	7,231	18
19	V	20	DUES AND SUBSCRIPTIONS		MADO MGMT, LP		1,335	1,335	19
20	V	21	CLERICAL AND GENERAL		MADO MGMT, LP		110,343	110,343	20
21	V	24	SEMINARS		MADO MGMT, LP		52	52	
22	V	25	AUTO EXPENSE		MADO MGMT, LP		3,362	3,362	22
23	V	26	PROPERTY INSURANCE		MADO MGMT, LP		5,461	5,461	23
24	V	<b>27</b>	GEN. ADMIN EMP. BEN.		MADO MGMT, LP		25,880	25,880	24
25	V	30	DEPRECIATION		MADO MGMT, LP		4,173	4,173	25
26	V		INTEREST		MADO MGMT, LP		19,335	19,335	
27	V	33	REAL ESTATE TAXES		MADO MGMT, LP		3,035	3,035	27
28	V								28
29	V	17	MANAGEMENT FEES	668,000	MADO MGMT, LP			(668,000)	29
30	V								30
31	V								31
32	V		<u> </u>						32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			s 668,000			s 206,813	\$ * (461,187)	39

<sup>\*</sup> Total must agree with the amount recorded on line 34 of Schedule VI.

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Facility Name & ID Number	Sacred Heart Home Inc.	# 0013334	Report Period Beginning:	01/01/04	Ending:	12/31/04
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# VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

X YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with

the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
		-		-	Percent	Operating Cost	Adjustments for	
Schedule V	Line	Item	Amount	Name of Related Organization	of	of Related	Related Organization	
					Ownership	Organization	Costs (7 minus 4)	
15 V	17	SALARY-D. O'BRIEN	\$	MADO MGMT. LP	100.00%			15
16 V	27	EMP. BEND. O'BRIEN		MADO MGMT. LP		5,634	5,634	16
17 V								17
18 V	17	SALARY-P. O'BRIEN		MADO MGMT. LP		39,718	39,718	18
19 V	27	EMP. BENP. O'BRIEN		MADO MGMT. LP		6,223	6,223	19
20 V								20
21 V								21
22 V								22
23 V								23
24 V								24
25 V								25
26 V								26
27 V	ļ							27
28 V	ļ							28
29 V								29 30
30 1								
31 V								31
								32
33	<u> </u>							33 34
	1							35
33 1	1							36
36 V 37 V	1							37
37 V 38 V	1							38
			-					
39 Total			8			s 91,293	\$ * 91,293	39

<sup>\*</sup> Total must agree with the amount recorded on line 34 of Schedule VI.

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Page 6C # 0013334 Facility Name & ID Number Sacred Heart Home Inc. Report Period Beginning: 01/01/04 Ending: 12/31/04

# VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, X YES management fees, purchase of supplies, and so forth.

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with

the instructions for determining costs as specified for this form.

	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
						Percent	Operating Cost	Adjustments for	
Sche	edule V	Line	Item	Amount	Name of Related Organization	of	of Related	Related Organization	
Sen	uuic ,	Line	Tem .	7 timount	Tunic of Related Organization	Ownership	Organization	Costs (7 minus 4)	
15	V	5	UTILITIES	•	MADO MGMT, LP	100.00%		Costs (/ mmus 4)	15
16	V	6	REPAIRS AND MAINTENANCE	J.	MADO MGMT. LP	100.00 /6	<b>3</b>	3	16
17	V	10	NURSING SALARY		MADO MGMT. LP		27,592	27,592	17
18	V	15	HEALTH CARE - EMP. BEN.		MADO MGMT. LP		6,712	6,712	18
	V		ADMINISTRATIVE SALARY					57,154	19
19	V	17 21			MADO MGMT, LP		57,154		
20	V	27	CLERICAL SALARY		MADO MGMT. LP		25,706	25,706	20
21	V		GEN. ADMIN EMP. BEN.		MADO MGMT. LP		7,105	7,105	21
22	V	30	DEPRECIATION-WAREHOUSE		MADO MGMT. LP				22
23		33	REAL ESTATE TAXES		MADO MGMT. LP				23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			s			s 124,269	s * 124,269	39

<sup>\*</sup> Total must agree with the amount recorded on line 34 of Schedule VI.

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Page 6D # 0013334 Facility Name & ID Number Sacred Heart Home Inc. Report Period Beginning: 01/01/04 Ending: 12/31/04

# VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, X YES management fees, purchase of supplies, and so forth.

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with

the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
		Ç		3	Percent	Operating Cost	Adjustments for
Schedule V	Line	Item	Amount	Name of Related Organization	of	of Related	Related Organization
					Ownership	Organization	Costs (7 minus 4)
15 V	01	Dietary	<b>\$</b> 49,710	Windy City Nursing	100.00%		
16 V	10	Nursing	517,694	Windy City Nursing	100.00%		16
17 V	11	Activities	22,802	Windy City Nursing	100.00%	22,802	17
18 V	12	Social Services	66,312	Windy City Nursing	100.00%		18
19 V	21	Office	89,818	Windy City Nursing	100.00%	89,818	19
20 V	04	Housekeeping	13,441	Windy City Nursing	100.00%	- /	20
21 V	06	Maintenance	60,838	Windy City Nursing	100.00%	60,838	21
22 V							22
23 V							23
24 V							24
25 V							25
26 V							26
27 V							27
28 V							28
29 V							29
30 V							30
31 V							31
32 V							32
33 V							33
34 V							34
35 V							35
36 V							36
37 V							37
38 V							38
39 Total			s 820,615			s 820,615	\$ *

<sup>\*</sup> Total must agree with the amount recorded on line 34 of Schedule VI.

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STATE OF ILLINOIS						F	Page 6E	
Facility Name & ID Number	Sacred Heart Home Inc.	#	0013334	Report Period Beginning:	01/01/04	Ending:	12/31/04	

# VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with

the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
		9			Percent	Operating Cost	Adjustments for
Schedule V	Line	Item	Amount	Name of Related Organization	of	of Related	Related Organization
Schedule v	Line	Tem	rimount	Name of Related Organization	Ownership		Costs (7 minus 4)
15 V			e e		Ownership	e	\$ 15
16 V			J			3	16
17 V							17
18 V							18
19 V							19
20 V				,			20
21 V							21
22 V							22
23 V							23
24 V							24
25 V							25
26 V							26
27 V							27
28 V							28
29 V							29
30 V							30
31 V							31
32 V							32
33 V							33
34 1							34
							35
30 V					1		36
37 V 38 V							37
<del> </del>							
39 Total			\$			<b>S</b>	\$ * 39

<sup>\*</sup> Total must agree with the amount recorded on line 34 of Schedule VI.

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		STATE OF ILLINOIS	S			F	Page 6F
Facility Name & ID Number	Sacred Heart Home Inc.	#	0013334	Report Period Beginning:	01/01/04	Ending:	12/31/04

# VII. RELATED PARTIES (continued)

B.	Are any costs included in this report which are a result of transactions wit	h rela	ited organizati	ions?	This includes rent
	management fees, purchase of supplies, and so forth.		YES		NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with

the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
		9			Percent	Operating Cost	Adjustments for
Schedule V	Line	Item	Amount	Name of Related Organization	of	of Related	Related Organization
Schedule v	Line	Tem	rimount	Name of Related Organization	Ownership		Costs (7 minus 4)
15 V			e e		Ownership	e	\$ 15
16 V			J			3	16
17 V							17
18 V							18
19 V							19
20 V				,			20
21 V							21
22 V							22
23 V							23
24 V							24
25 V							25
26 V							26
27 V							27
28 V							28
29 V							29
30 V							30
31 V							31
32 V							32
33 V							33
34 1							34
							35
30 V					1		36
37 V 38 V							37
<del> </del>							
39 Total			\$			<b>S</b>	\$ * 39

<sup>\*</sup> Total must agree with the amount recorded on line 34 of Schedule VI.

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Page 6G # 0013334 Facility Name & ID Number Sacred Heart Home Inc. Report Period Beginning: 01/01/04 Ending: 12/31/04

# VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, YES NO management fees, purchase of supplies, and so forth.

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with

the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
		9			Percent	Operating Cost	Adjustments for
Schedule V	Line	Item	Amount	Name of Related Organization	of	of Related	Related Organization
Schedule v	Line	Tem	rimount	Name of Related Organization	Ownership		Costs (7 minus 4)
15 V			e e		Ownership	e	\$ 15
16 V			<b>J</b>			3	16
17 V							17
18 V							18
19 V							19
20 V				,			20
21 V							21
22 V							22
23 V							23
24 V							24
25 V							25
26 V							26
27 V							27
28 V							28
29 V							29
30 V							30
31 V							31
32 V							32
33 V							33
34 1							34
							35
30 V					1		36
37 V 38 V							37
<del> </del>							
39 Total			\$			<b>S</b>	\$ * 39

<sup>\*</sup> Total must agree with the amount recorded on line 34 of Schedule VI.

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Page 6H # 0013334 Facility Name & ID Number Sacred Heart Home Inc. Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued	VII.	RELA	TED	PARTIES	(continued
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B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, YES NO management fees, purchase of supplies, and so forth.

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with

the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
		9			Percent	Operating Cost	Adjustments for
Schedule V	Line	Item	Amount	Name of Related Organization	of	of Related	Related Organization
Schedule v	Line	Tem	rimount	Name of Related Organization	Ownership		Costs (7 minus 4)
15 V			e e		Ownership	e	\$ 15
16 V			J			3	16
17 V							17
18 V							18
19 V							19
20 V				,			20
21 V							21
22 V							22
23 V							23
24 V							24
25 V							25
26 V							26
27 V							27
28 V							28
29 V							29
30 V							30
31 V							31
32 V							32
33 V							33
34 1							34
							35
30 V					1		36
37 V 38 V							37
<del> </del>							
39 Total			\$			<b>S</b>	\$ * 39

<sup>\*</sup> Total must agree with the amount recorded on line 34 of Schedule VI.

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SIAIL	OF ILLINOIS

		STATE OF ILLINOIS			F	Page 6I
Facility Name & ID Number	Sacred Heart Home Inc.	# 0013334	Report Period Beginning:	01/01/04	Ending:	12/31/04

VII. RELATED PARTIES (continued)	
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B.	Are any costs included in this report which are a result of transactions wit	h rela	ted organizat	ions?	This includes rent,
	management fees, purchase of supplies, and so forth.		YES		NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with

the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
		9			Percent	Operating Cost	Adjustments for
Schedule V	Line	Item	Amount	Name of Related Organization	of	of Related	Related Organization
Schedule v	Line	Tem	rimount	Name of Related Organization	Ownership		Costs (7 minus 4)
15 V			e e		Ownersnip	e	\$ 15
16 V			J			3	16
17 V							17
18 V							18
19 V							19
20 V				,			20
21 V							21
22 V							22
23 V							23
24 V							24
25 V							25
26 V							26
27 V							27
28 V							28
29 V							29
30 V							30
31 V							31
32 V							32
33 V							33
34 1							34
							35
30 V					1		36
37 V 38 V							37
<del> </del>							
39 Total			\$			<b>S</b>	\$ * 39

<sup>\*</sup> Total must agree with the amount recorded on line 34 of Schedule VI.

Sacred Heart Home Inc.

# 0013334

**Report Period Beginning:** 

01/01/04

Ending:

12/31/04

# VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hou	rs Per Work				
					Compensation	Week Devo	ted to this	Compensation	on Included	Schedule V.	
					Received	Facility and % of Total		in Costs for this		Line &	
				Ownership	From Other	Work	Week	Reportin	g Period**	Column	
	Name	Title	Function	Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
1	Daniel O'Brien	Owner	Administrative	20.00%	See Attached	5.60	14.00%	Allocated	\$ 39,718	17-7	1
2	Peter O'Brien	Owner	Administrative	60.00%	See Attached	10.70	17.83%	Allocated	39,718	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10							•				10
11											11
12											12
13								TOTAL	\$ 79,436		13

<sup>\*</sup> If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

<sup>\*\*</sup> This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).

FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

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F	Facility Name & ID Number Sacred Heart Home Inc.			# 0013334	Report Period Beginning:	01/01/04	Ending:	12/31/04				
V	III. ALLOC	CATION OF INDIRECT COS	TS									
							ated Organization					
			eport which were derived from			Street Addre						
	or pare	ent organization costs? (See in	structions.) YES	NO	X	X City / State / Zip Code						
	D CL . 4		6	J 4		Phone Numb		<u> </u>				
	B. Snow ti	ne allocation of costs below. 11	f necessary, please attach works	sneets.		Fax Number	<u>(</u>	)				
	1	2	3	4	5	6	7	8	9			
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary					
	Line		(i.e., Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Facility	Allocation			
	Reference	Item	Square Feet)	<b>Total Units</b>	Allocated Among	Allocated	in Column 6	Units	(col.8/col.4)x col.6			
1						\$	\$		\$	1		
2										2		
3										3		
4										4		
5										5		
5										6		
/									+	7 8		
0									+	9		
.0			+			+			+	10		
1									+	11		
2						_			+	12		
3									+	13		
4									1	14		
5										15		
6										16		
7										17		
8										18		
9										19		
0										20		
1										21		
3										22		
										23		
4							_			24		
5 T	OTALS					\$	\$		\$	25		

# VIII. ALLOCATION OF INDIRECT COSTS

	Name of Related Organization	MADO MGMT. LP
A. Are there any costs included in this report which were derived from allocations of central office	Street Address	1541 N. WELLS ST.
or parent organization costs? (See instructions.)  YES X  NO	City / State / Zip Code	CHICAGO, IL. 60610
<del>_</del>	Phone Number	( 312) 787-9400
B. Show the allocation of costs below. If necessary, please attach worksheets.	Fax Number	( 312) 787-9434

	1	2	3	4	5	6	7	8	9	
	Schedule V	_	Unit of Allocation	-	Number of	Total Indirect	Amount of Salary		•	
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Facility	Allocation	
	Reference	Item	Square Feet)	<b>Total Units</b>	Allocated Among	Allocated	in Column 6	Units	(col.8/col.4)x col.6	
1	5	UTILITIES	PATIENT DAYS	244,284	5	\$ 5,309	\$	57,073	\$ 1,240	1
2	6	REPAIRS AND MAINT.	PATIENT DAYS	244,284	5	16,071		57,073	3,755	2
3	17	ADMINISTRATIVE	PATIENT DAYS	244,284	5	92,500	92,500	57,073	21,611	3
4		PROFESSIONAL FEES	PATIENT DAYS	244,284	5	30,950		57,073	7,231	4
5		DUES AND SUBSCRIPTIONS	PATIENT DAYS	244,284	5	5,714		57,073	1,335	5
6		CLERICAL AND GENERAL	PATIENT DAYS	244,284	5	472,288	406,985	57,073	110,343	6
7		SEMINARS	PATIENT DAYS	244,284	5	221		57,073	52	7
8	25	AUTO EXPENSE	PATIENT DAYS	244,284	5	14,390		57,073	3,362	8
9		PROPERTY INSURANCE	PATIENT DAYS	244,284	5	23,374		57,073	5,461	9
10		GEN. ADMIN EMP. BEN.	PATIENT DAYS	244,284	5	110,773		57,073	25,880	10
11		DEPRECIATION	PATIENT DAYS	244,284	5	17,861		57,073	4,173	11
12		INTEREST	PATIENT DAYS	244,284	5	82,756		57,073	19,335	12
13	33	REAL ESTATE TAXES	PATIENT DAYS	244,284	5	12,989		57,073	3,035	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 885,196	\$ 499,485		\$ 206,813	25

STATE	OF	ILLINOIS	

Page 8B

Facility Name & ID Number Sacred Heart Home Inc. # 0013334 Report Period Beginning: 01/01/04 Ending: 12/31/04

# VIII. ALLOCATION OF INDIRECT COSTS

	Name of Related Organization	MADO MGMT. LP
A. Are there any costs included in this report which were derived from allocations of central office	Street Address	1541 N. WELLS ST.
or parent organization costs? (See instructions.)  YES X  NO	City / State / Zip Code	CHICAGO, IL. 60610
<del>_</del>	Phone Number	( 312) 787-9400
B. Show the allocation of costs below. If necessary, please attach worksheets	Fax Number	( 312) 787-9434

	1	2	3	4	5	6	7	8	9	$\Box$
	Schedule V	_	Unit of Allocation		Number of	Total Indirect	Amount of Salary		•	
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Facility	Allocation	
	Reference	Item	Square Feet)	<b>Total Units</b>	Allocated Among	Allocated	in Column 6	Units	(col.8/col.4)x col.6	
1	17	SALARY-D. O'BRIEN	AVG. HOURS WORKED	24	5	170,000	170,000	6	39,718	1
2	27	EMP. BEND. O'BRIEN	AVG. HOURS WORKED	24	5	24,116		6	5,634	2
3										3
4		SALARY-P. O'BRIEN	AVG. HOURS WORKED		5	170,000	170,000	11	39,718	4
5	27	EMP. BENP. O'BRIEN	AVG. HOURS WORKED	46	5	26,636		11	6,223	5
6										6
7										7
8										8
9										9
10 11										10 11
12										12
13										13
14										14
15										15
16			1							16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 390,752	\$ 340,000		\$ 91,293	25

C	TATI	E OF I	LLINOIS	

Page 8C # 0013334 Report Period Beginning: 01/01/04 Ending: 12/31/04

# VIII. ALLOCATION OF INDIRECT COSTS

Facility Name & ID Number

Name of Related Organization MADO MGMT, LP A. Are there any costs included in this report which were derived from allocations of central office Street Address 1541 N. WELLS ST. or parent organization costs? (See instructions.) YES X City / State / Zip Code CHICAGO, IL. 60610 Phone Number ( 312) 787-9400 Fax Number ( 312) 787-9434

B. Show the allocation of costs below. If necessary, please attach worksheets.

Sacred Heart Home Inc.

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary			
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Facility	Allocation	
	Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6	Units	(col.8/col.4)x col.6	
1	5	UTILITIES	DIRECT ALLOCATION		1	34			,	1
2	6	REPAIRS AND MAINTENANCE	DIRECT ALLOCATION		1					2
3	10	NURSING SALARY	DIRECT ALLOCATION		2	56,592	56,592		27,592	3
4	15	HEALTH CARE - EMP. BEN.	DIRECT ALLOCATION		2	10,551			6,712	4
5	17	ADMINISTRATIVE SALARY	DIRECT ALLOCATION		5	292,744	292,744		57,154	5
6	21	CLERICAL SALARY	DIRECT ALLOCATION		2	55,306	55,306		25,706	6
7	27	GEN. ADMIN EMP. BEN.	DIRECT ALLOCATION		5	70,268			7,105	7
8	30	<b>DEPRECIATION-WAREHOUSE</b>			1	216				8
9	33	REAL ESTATE TAXES	DIRECT ALLOCATION		1	2,182				9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 487,893	\$ 404,642		\$ 124,269	25

STA	TE	OF	TT '	IIN	rc
O I A		OF.	IL.	LIII	 L.

Page 8D # 0013334 Report Period Beginning: Facility Name & ID Number Sacred Heart Home Inc. 01/01/04 Ending: 12/31/04

# VIII. ALLOCATION OF INDIRECT COSTS

	Name of Related Organization	WINDY CITY NURSING
A. Are there any costs included in this report which were derived from allocations of central office	Street Address	1541 N. WELLS ST.
or parent organization costs? (See instructions.)  YES X  NO	City / State / Zip Code	CHICAGO, IL. 60610
	Phone Number	( 312) 787-9400
B. Show the allocation of costs below. If necessary, please attach worksheets.	Fax Number	312) 787-9434

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary			
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Facility	Allocation	
	Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6	Units	(col.8/col.4)x col.6	
1			Direct Allocation			\$	\$		\$ 49,710	1
2	10		Direct Allocation			•			517,694	2
3	11		Direct Allocation						22,802	3
4	12	Social Services	Direct Allocation						66,312	4
5	21	Office	Direct Allocation						89,818	5
6	04	Housekeeping	Direct Allocation						13,441	6
7	06	Maintenance	Direct Allocation						60,838	7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21							ļ			21
22							ļ			22
23										23
24										24
25	TOTALS					\$	\$		\$ 820,615	25

STATE OF ILLINOIS	Page 8E

	Facility Name	e & ID Number Sacred Hear	rt Home Inc.		# 0013334	Report Period Beginning:	01/01/04	Ending:	12/31/04	
	VIII. ALLOC	CATION OF INDIRECT COSTS				Name of Pol	ated Organization			
	A Are the	ere any costs included in this repo	rt which were derived fron	n allocations of centr	al office	Street Addre			_	
		ent organization costs? (See instru				City / State /				
	or part	one organization costs: (See Institu	125	1.0		Phone Numb	per (	)	_	
	B. Show th	he allocation of costs below. If neo	cessary, please attach work	sheets.		Fax Number	· <u>(</u>	)		
	1	2	3	4	5	6	7	8	9	
	Schedule V	_	Unit of Allocation	•	Number of	Total Indirect	Amount of Salary	· ·		
	Line		(i.e., Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Facility	Allocation	
	-		` ' · ' '		8					
	Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6	Units	(col.8/col.4)x col.6	-
1						\$	2		2	1
3										3
4			+			+				4
5										5
6			+			_				6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18 19										18 19
20										20
21									+	21
22										22
23										23
24										24
	TOTALS					s	\$		\$	25

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	Facility Name	e & ID Number Sacred Hear	t Home Inc.		# 0013334	Report Period Beginning:	01/01/04	Ending:	12/31/04	
	VIII. ALLOC	CATION OF INDIRECT COSTS				Name of Pol	ated Organization			
	A. Are the	ere any costs included in this repor	t which were derived fron	n allocations of centr	al office	Street Addre				
		ent organization costs? (See instruc				City / State /				
			,	<u> </u>	<u> </u>	Phone Numb	oer (	)		
	B. Show th	he allocation of costs below. If nec	essary, please attach work	xsheets.		Fax Number	<u>(</u>	)		
	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary			
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Facility	Allocation	
	Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6	Units	(col.8/col.4)x col.6	
1			•			\$	\$		\$	1
2										2
3										3
4										4
5										5
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16 17										16 17
18										18
19										19
20										20
21								ĺ		21
22										22
23										23
24								_		24
25	TOTALS					s	\$		\$	25

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25

	Facility Name	e & ID Number Sacred He	art Home Inc.		# 0013334 I	Report Period Beginning:	01/01/04	Ending:	12/31/04	
	VIII. ALLOC	CATION OF INDIRECT COSTS	S			Name of Rela	ated Organization			
	A. Are the	ere any costs included in this rep	ort which were derived from	allocations of centr	al office	Street Addre				
		ent organization costs? (See instr		NO		City / State /			_	
		<b>9</b>				Phone Numb		)	_	
	B. Show th	he allocation of costs below. If n	ecessary, please attach work	sheets.		Fax Number	(	)		
	1	2	3	4	5	6	7	8	9	$\top$
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary			
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Facility	Allocation	
	Reference	Item	Square Feet)	<b>Total Units</b>	Allocated Among	Allocated	in Column 6	Units	(col.8/col.4)x col.6	
1			•		J	\$	\$		\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11 12										11
13			_							13
14	-							-		14
15										15
16										16
17						+				17
18										18
19										19
20										20
21										21
22										22
23										23
24				<u> </u>						24

25 TOTALS

STATE OF ILLINOIS	Page 8H
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	Facility Name	e & ID Number Sacred Hea	rt Home Inc.		# 0013334	Report Period Beginning:	01/01/04	Ending:	12/31/04	
	VIII. ALLOC	CATION OF INDIRECT COSTS				N CD I	. 10			
	A Arotho	ere any costs included in this repo	ort which were derived from	allocations of contr	al office	Name of Rei	ated Organization			
		ent organization costs? (See instru		NO	ai office	City / State /				
	or parc	the organization costs. (See Instit	ictions.)			Phone Numb	er 7			
	B. Show th	he allocation of costs below. If ne	ecessary, please attach work	sheets.		Fax Number		<u> </u>		
			V / I							
	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary			
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Facility	Allocation	
	Reference	Item	Square Feet)	<b>Total Units</b>	Allocated Among	Allocated	in Column 6	Units	(col.8/col.4)x col.6	
1			a quant or sony			\$	\$		\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11									<u> </u>	11
12										12
13 14									<del> </del>	13 14
15			+						+	15
16									+	16
17										17
18										18
19									1	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

STATE OF ILLINOIS	Page 8I
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	Facility Name	e & ID Number Sacred	l Heart Home Inc.		# 0013334 I	Report Period Beginning:	01/01/04	Ending:	12/31/04	
	VIII. ALLO	CATION OF INDIRECT CO	OSTS							
							ated Organization		_	
			report which were derived from		al office	Street Addre				
	or par	ent organization costs? (See i	instructions.) YES	NO		City / State /				
	D Ch 4	h ll t' f t - h - l	If a common along office has	h		Phone Number		<u> </u>		
	B. Snow t	ne anocation of costs below.	If necessary, please attach work	sneets.		rax Number	<u>(</u>			
	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary			
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Facility	Allocation	
	Reference	Item	Square Feet)	<b>Total Units</b>	Allocated Among	Allocated	in Column 6	Units	(col.8/col.4)x col.6	
1						\$	\$		\$	1
2										2
3										3
4										4
5										5
6										6
7										7
9									<del>                                     </del>	9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21									<u> </u>	21
22		1							<u> </u>	22
23										23
24						_	_			24
25	TOTALS					\$	\$		<b>S</b>	25

	STATE OF ILLINOIS				
Facility Name & ID Number	Sacred Heart Home Inc.	# 0013334 Report Period Beginning: 01/01/04 Ending:	12/31/04		
-		the state of the s			

IX.	INTEREST	EXPENSE	AND	REAL	ESTATE	TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1 2 3 4 5 6 7 8 9 10

	1	2	3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amor Original	unt of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related									•	
	Long-Term										
1	- C					\$	\$			\$	1
2											2
3											3
4											4
5	See Supplemental Schedule										5
	Working Capital										
6	TiffCo	X	Insurance Financing							797	6
7	Alloc-MADO Management	X								19,335	7
8	See Supplemental Schedule										8
9	TOTAL Facility Related					\$	\$			\$ 20,132	9
	B. Non-Facility Related*			•	<u> </u>	T			<u> </u>		
10											10
11											11
12											12
13	See Supplemental Schedule										13
14	TOTAL Non-Facility Related					\$	\$			\$	14
15	TOTALS (line 9+line14)					\$	\$			\$ 20,132	15

16)	Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V.	\$ 0	Line #	N/A	

<sup>\*</sup> Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

<sup>\*\*</sup> If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Sacred Heart Home Inc. STATE OF ILLINOIS Page 9 - SUPPLEMENTAL # 0013334 Report Period Beginning: 01/01/04 Ending: 12/31/04

# IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

2 10 Reporting Monthly Maturity Interest Period Name of Lender Related\*\* **Purpose of Loan Payment Amount of Note** Date Rate Interest Date of YES NO Required Original (4 Digits) Note Balance Expense A. Directly Facility Related Long-Term 1 2 2 3 3 4 4 5 5 6 6 7 TOTAL Long-Term 7 **Working Capital** 8 9 9 10 10 11 11 12 12 13 13 14 14 TOTAL Working Capital B. Non-Facility Related\* 15 15 16 16 17 17 18 18 19 19 20 TOTAL Non-Facility Related 20

<sup>\*</sup> Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.

(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

<sup>\*\*</sup> If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Sacred Heart Home Inc.

STATE OF ILLINOIS

# 0013334 Report Period Beginning: 01/01/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

	Important, please see the next worksheet,	"RE_Tax". The real	estate tax statement and			
1. Real Estate Tax accrual used on 2003 report.	bill must accompany the cost report.			\$	3,303	1
2. Real Estate Taxes paid during the year: (Indicate the	2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)					
3. Under or (over) accrual (line 2 minus line 1).						3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)						4
5. Direct costs of an appeal of tax assessments which he (Describe appeal cost below. Attach cop	\$		5			
6. Subtract a refund of real estate taxes. You must off classified as a real estate tax cost plus one-half of ar TOTAL REFUND \$ For	7 11	eal estate tax appeal	board's decision.)	\$		6
7. Real Estate Tax expense reported on Schedule V, lin	ne 33. This should be a combination of lines 3 thru 6.			\$	5,927	
Real Estate Tax History:						7
						7
Real Estate Tax Bill for Calendar Year: 199	9 1,075 8		FOR OHF USE ONLY			7
Real Estate Tax Bill for Calendar Year: 199 200 200	3,101 9	13	FOR OHF USE ONLY FROM R. E. TAX STATEMENT F	FOR 2003	\$	
200 200 200 200 200	0 3,101 9 1 3,181 10 2 3,217 11	13			s s	13
200 200 200 200 200 Accrual = 2833 x 1.18	0 3,101 9 1 3,181 10 2 3,217 11	14	FROM R. E. TAX STATEMENT F		•	13
200 200 200 200 200	0 3,101 9 1 3,181 10 2 3,217 11		FROM R. E. TAX STATEMENT F		•	13

NOTES:

- 1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
- If facility is a non-profit which pays real estate taxes, you must attach a denial of an
  application for real estate tax exemption unless the building is rented from a for-profit entity.
  This denial must be no more than four years old at the time the cost report is filed.

#### IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

# 2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FAC	ILITY NAME Sacred Heart I	Home Inc.			COUNTY	Cook	
FAC	LILITY IDPH LICENSE NUMBER	R 0013334					
CON	TACT PERSON REGARDING T	HIS REPORT Steve Lav	enda				
TEL	EPHONE (847)236-1111		FAX#:	(847)236-1	155		
A.	Summary of Real Estate Tax C	ost	_				
	Enter the tax index number and recost that applies to the operation home property which is vacant, rentered in Column D. Do not inc	eal estate tax assessed for 2 of the nursing home in Col ented to other organization	lumn D. Re s, or used f	eal estate tax or purposes o	applicable to ther than long	any portion	of the nursing
	(A)	(B)			(C)		(D)
	Tax Index Number	Property Descr	iption_		Total Tax		Tax Applicable to Nursing Home
1.	16-24-106-035	Long Term Care		\$	364.11	\$	364.11
2.	16-24-106-036	Long Term Care		\$	713.68	\$_	713.68
3.	16-24-106-067	Long Term Care		\$	1,755.63	\$_	1,755.63
4.		Home Office Allocati	on	\$	13,450.22	\$_	3,142.43
5.				\$_		_ \$_	
6.				\$			
7.				\$		\$_	
8.				\$		\$	
9.				\$		\$_	
10.				_ \$		_ \$_	
			TOTALS	s_	16,283.64	\$_	5,975.85
B.	Real Estate Tax Cost Allocation	<u>18</u>					
	Does any portion of the tax bill a used for nursing home services?	pply to more than one nurs  X YES	ing home,	vacant proper _NO	ty, or propert	y which is n	ot directly
	If YES, attach an explanation & a (Generally the real estate tax cost						ome.

C. <u>Tax Bills</u>

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

#### IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

# 2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FAC	ILITY NAME	Sacred Heart Home	Inc.	COUNTY	Cook
FAC	ILITY IDPH LICE	ENSE NUMBER 0	013334	_	
CON	TACT PERSON I	REGARDING THIS F	REPORT Steve Lavenda		
TEL	EPHONE (847)2:	36-1111	FAX#:	(847)236-1155	<u> </u>
A.	Summary of Rea	al Estate Tax Cost			
	cost that applies t home property w	to the operation of the hich is vacant, rented	tate tax assessed for 2000 on the nursing home in Column D. Re to other organizations, or used foost for any period other than ca	eal estate tax applicable to or purposes other than lor	any portion of the nursing
	(A	)	(B)	(C)	(D) Tax
	Tax Index	<u>Number</u>	Property Description	<u>Total Tax</u>	Applicable to Nursing Home
1.					
2.				<u> </u>	
3.				_	
4.		<del></del>	<u> </u>	_	
5.		<del></del>		_	
6. 7				_	
8.				_	
9.				\$ \$	
10.				- \$ \$	\$
				<u> </u>	
			TOTALS	s	<u> </u>
B.	Real Estate Tax	Cost Allocations			
	Does any portion used for nursing l		o more than one nursing home, YES		ty which is not directly
			dule which shows the calculation be allocated to the nursing home		
C	Tay Pills				

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which

is normally paid during 2001.

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STATE C	STATE OF ILLINOIS				Page 11
#	0013334	Report Period Beginning:	01/01/04	<b>Ending:</b>	12/31/04

			STAT	E OF ILLINOIS		Page 11				
Facil	ity Name & ID Number Sacred Hear	t Home Inc.		# 0013334 Report Period Beginnin	ng: 01/01/04 Ending:	12/31/04				
X. B	UILDING AND GENERAL INFORM	IATION:								
A.	Square Feet: 79,94	<b>B.</b> General Construction Type:	Exterior	Frame	Number of Stories	3				
C.	Does the Operating Entity?	(a) Own the Facility	X (b) Rent from a Relat	ed Organization.	(c) Rent from Completely Unre Organization.	lated				
	(Facilities checking (a) or (b) must of	complete Schedule XI. Those checking (c)	may complete Schedule XI or	Schedule XII-A. See instructions.)	g					
D.	Does the Operating Entity?	X (a) Own the Equipment	(b) Rent equipment fr	om a Related Organization.	X (c) Rent equipment from Comp Unrelated Organization.	oletely				
	(Facilities checking (a) or (b) must of	complete Schedule XI-C. Those checking	(c) may complete Schedule XI	-C or Schedule XII-B. See instructions.)	9					
Е.	E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.)  List entity name, type of business, square footage, and number of beds/units available (where applicable).  None									
F.	Does this cost report reflect any org If so, please complete the following:	anization or pre-operating costs which a	re being amortized?	YES	X NO					
1.	. Total Amount Incurred:		2. Nui	nber of Years Over Which it is Being An	nortized:					
3.	. Current Period Amortization:		4. Dat	es Incurred:						
		Nature of Costs: (Attach a complete schedule deta	niling the total amount of orga	nization and pre-operating costs.)						
XI. C	OWNERSHIP COSTS:									
1111	, , , , , , , , , , , , , , , , , , ,	1	2	3 4						
	A. Land.	Use	Square Feet Y	Year Acquired Cost						
		1 Facility		\$ 22,07						
		3 TOTALS		\$ 22,07	$\frac{2}{7}$					
		3 IUIALS		\$ 22,07	1 3					

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Facility Name & ID Number Sacred Heart Home Inc. # 001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment, (See instructions.) Round all numbers to nearest dollar.

	B. Build	ing Depreciation-Including Fixed Equ	uipment. (See inst	ructions.) Koun	a an numbers to near	rest dollar.					
	1		2	3	4	5	6	7	8	9	
		FOR OHF USE ONLY	Year	Year		Current Book	Life	Straight Line		Accumulated	
	Beds*		Acquired	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Impr	ovement Type**									
9	Various	71.		1973	9,000		20	_		9,000	9
	Various			1975	16,880		20	-		16,880	10
11	Various			1976	4,234		20	-		4,234	11
12	Various			1977	43,234		20	-		43,234	12
13	Various			1978	50,867		20	-		50,867	13
14	Various			1979	40,393		20	-		40,393	14
15	Various			1980	4,392		20	_		4,392	15
16	Various			1981	15,817		20	-		15,817	16
17	Various			1982	15,180		20	-		15,180	17
18	Various			1984	7,505		20	-		7,505	18
19	Various			1985	60,377		20	-		60,377	19
20	Various			1986	41,792		20	-		41,792	20
	Various			1987	17,344		20	-		17,344	21
	Various			1988	13,840		20	-		13,824	22
	Various			1989	10,568		20	-		10,568	23
	Various			1990	48,324		20	1,444	1,444	48,322	24
-	Various			1991	26,113		20	132	132	25,126	25
26	Various			1992	105,671		20	5,284	5,284	94,078	26
27	Various			1993	14,487		20	666	666	14,487	27
28	Various	·		1994	37,950		20	1,898	1,898	20,877	28
29	Various	·		1995	38,705		20	1,935	1,935	17,416	29
	Various	·		1996	34,431		20	1,721	1,721	15,823	30
31	Various			1997	62,792		20	3,143	3,143	23,416	31
	Various			1998	73,236		20	3,664	3,664	24,742	32
	Various	·		1999	51,272		20	2,563	2,563	14,030	33
	Various			2000	120,486		20	6,028	6,028	27,853	34
35								-		-	35
36								_		_	36

See Page 12A, Line 70 for total SEE ACCOUNTANTS' COMPILATION REPORT

<sup>\*</sup>Total beds on this schedule must agree with page 2.
\*\*Improvement type must be detailed in order for the cost report to be considered complete.

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

I l	3	4	5	6	7	8	9	
	Year		Current Book	Life	Straight Line		Accumulated	
Improvement Type**	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50 51								50 51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66		140 000					140 000	66
67 Related Building Company (Pages 12-BLDG & 12A-BLDG)		140,000	2.405		2 724	241	140,000	67
68 Related Party Allocations (Pages 12-REP & 12A-REP)		74,194	2,495		2,736	(66,234)	24,838	68
69 Financial Statement Depreciation 70 TOTAL (lines 4 thru 69)		0 1 170 004	66,234		0 21 214		0 043 415	69 70
/U [101AL (IIIIES 4 tHru 09)	1	\$ 1,179,084	\$ 68,729		\$ 31,214	\$ (37,515)	\$ 842,415	//

<sup>\*\*</sup>Improvement type must be detailed in order for the cost report to be considered complete.

Page 12B Facility Name & ID Number Sacred Heart Home Inc. # 001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar. # 0013334 Report Period Beginning: 01/01/04 Ending: 12/31/04

B. Building Depreciation-Including Fixed Equipment.	3	4	5	6	7	8	9	$\overline{}$
•	Year	•	Current Book	Life	Straight Line	v	Accumulated	
Improvement Type**	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
1 Totals from Page 12A, Carried Forward		s 1,179,084	\$ 68,729		\$ 31,214	\$ (37,515)	\$ 842,415	1
2 Air Conditioners	2001	5,208		20	260	260	911	2
3 Verticle Blinds	2001	1,778		20	89	89	349	3
4 Air Conditioners	2001	10,403		20	520	520	1,777	4
5 Pipes & Fittings	2001	1,089		20	54	54	217	5
6 Chainlink Fencing	2001	1,041		20	52	52	208	6
7 120V Coil	2001	818		20	41	41	161	7
8 Radiator Cabinet	2001	4,052		20	203	203	794	8
9 Handrails	2001	2,400		20	120	120	460	9
10 Hot Water Line	2001	1,460		20	73	73	280	10
11 Metal Door	2001	1,327		20	66	66	254	11
12 Steel Pipe Columns	2001	4,850		20	243	243	910	12
13 Floor Tiles	2001	10,151		20	508	508	1,946	13
14 Floor Tiles	2001	5,890		20	295	295	1,105	14
15 Security Monitor	2001	732		20	37	37	138	15
16 Security Cameras	2001	1,239		20	62	62	233	16
17 Security Monitor Cam	2001	1,073		20	54	54	197	17
18 Installed Heater	2001	670		20	34	34	124	18
19 Tubs	2001	2,256		20	113	113	413	19
20 Water Lines	2001	11,072		20	554	554	2,077	20
21 Verticle Blinds	2001	1,778		20	89	89	349	21
22 Handrails	2001	600		20	30	30	108	22
23 Fence	2001	13,132		20	657	657	2,134	23
24 Roof	2001	27,150		20	1,358	1,358	4,299	24
25 Fence	2001	1,475		20	74	74	227	25
26 Handrail Bars	2001	4,500		20	225	225	694	26
27 Elevator Repair	2001	4,324		20	216	216	865	27
28 Paint	2001	673		20	34	34	135	28
29 Paint	2001	631		20	32	32	119	29
30 Boiler Repair	2001	765		20	38	38	134	30
31 Plumbing	2001	854		20	43	43	150	31
32 Fence	2001	7,340		20	367	367	1,223	32
33 Wiring	2001	1,777		20	89	89	297	33
34 TOTAL (lines 1 thru 33)		s 1,311,592	\$ 68,729		\$ 37,844	\$ (30,885)	\$ 865,703	34

<sup>\*\*</sup>Improvement type must be detailed in order for the cost report to be considered complete.

Page 12C 12/31/04

01/01/04 Ending:

Facility Name & ID Number Sacred Heart Home Inc. # 001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar. # 0013334 Report Period Beginning:

1	3	4	5	6	7	8	9	
	Year		Current Book	Life	Straight Line		Accumulated	
Improvement Type**	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
1 Totals from Page 12B, Carried Forward		s 1,311,592	\$ 68,729		\$ 37,844	\$ (30,885)	\$ 865,703	1
2 Landscape Rocks	2001	500		20	25	25	83	2
3 Fence	2001	2,142		20	107	107	348	3
4 Elevator Repair	2001	726		20	36	36	130	4
5 Water Lines	2001	2,744		20	137	137	446	5
6 Roofing Materials	2001	698		20	35	35	111	6
7 Sink	2001	627		20	31	31	99	7
8 Compressor	2001	1,750		20	88	88	300	8
9 Access Ladders	2001	3,750		20	188	188	594	9
10 Fence	2001	1,722		20	86	86	272	10
11 Fixed Ladder Guard	2001	870		20	44	44	135	11
12 Fence	2001	2,645		20	132	132	408	12
13 Roof Work	2001	975		20	49	49	150	13
14 Fence	2001	3,235		20	162	162	499	14
15 Paint	2001	3,033		20	152	152	468	15
16 Fire Safety Painting	2001	1,795		20	90	90	277	16
17 Indoor Security Camera	2002	5,354		20	765	765	1,848	17
18 Ceiling Supplies	2002	552		20	55	55	166	18
19 Vertical Blinds	2002	2,610		20	261	261	783	19
20 Door Repairs/Smoke Stack	2002	800		20	80	80	233	20
21 Shower Plumbing	2002	4,690		20	469	469	1,329	21
22 Door Supplies	2002	1,040		20	104	104	277	22
23 Power Hide-Walls	2002	1,270		20	127	127	339	23
24 Gutter/Roof Repairs	2002	2,500		20	250	250	667	24
25 Gutter/Down Spouts/Roof Repairs	2002	2,000		20	200	200	533	25
26 Gutter/Down Spouts/Roof Repairs	2002	2,700		20	270	270	720	26
27 Clearcoat-Floors	2002	548		20	55	55	146	27
28 Removal/Installation Of Walls	2002	3,319		20	332	332	885	28
29 Vertical Blinds	2002	1,351		20	135	135	372	29
30 Door & Frames	2002	2,989		20	299	299	797	30
31 Door & Frames	2002	2,300		20	230	230	613	31
32 Door & Frames	2002	791		20	79	79	211	32
33 Gutter/Down Spouts/Roof Repairs	2002	4,700		20	470	470	1,253	33
34 TOTAL (lines 1 thru 33)		\$ 1,378,318	\$ 68,729		\$ 43,387	\$ (25,342)	\$ 881,195	34

<sup>\*\*</sup>Improvement type must be detailed in order for the cost report to be considered complete.

Page 12D 12/31/04 Facility Name & ID Number Sacred Heart Home Inc. # 001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar. # 0013334 Report Period Beginning: 01/01/04 Ending:

1	3	4	5	6	7	8	9	
	Year		Current Book	Life	Straight Line		Accumulated	
Improvement Type**	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
1 Totals from Page 12C, Carried Forward		s 1,378,318	\$ 68,729		\$ 43,387	\$ (25,342)	\$ 881,195	1
2 Gutter/Down Spouts/Roof Repairs	2002	2,000		20	200	200	533	2
3 Gutter/Down Spouts/Roof Repairs	2002	1,500		20	150	150	400	3
4 Gate And Fence	2002	1,234		20	123	123	329	4
5 Gate And Fence	2002	685		20	69	69	183	5
6 Generator And Remote Panel	2002	19,825		20	1,983	1,983	4,956	6
7 Base Paint	2002	880		20			880	7
8 Closet Repairs	2002	968		20	97	97	250	8
9 Concrete And Tile Removal	2002	1,890		20	189	189	488	9
10 Door Alarms	2002	513		20	73	73	171	10
11 Landscaping	2002	2,481		20	165	165	372	11
12 Door Closer	2002	557		20	56	56	125	12
13 Elevator Painting	2002	1,959		20	196	196	571	13
14 Fence Repairs	2002	750		20	75	75	169	14
15 Fire Escape Repairs	2002	8,543		20	854	854	1,922	15
16 Gate Installation	2002	2,335		20	234	234	486	16
17 Gate/Fence Repairs	2002	865		20	87	87	195	17
18 Hallway And Ceiling Repairs	2002	1,597		20	160	160	333	18
19 Lighting Repairs	2002	504		20	50	50	122	19
20 Painting Fire Escape	2002	3,136		20	314	314	784	20
21 Painting Frames And Steps	2002	1,312		20	131	131	317	21
22 Painting Supplies	2002	3,944		20	394	394	855	22
23 Parking Lot Repairs	2002	863		20	58	58	153	23
24 Pipe Repairs	2002	704		20	70	70	158	24
25 Renovation Of Storage Floor	2002	1,243		20	124	124	300	25
26 Replacement Of Hallway Tiles	2002	2,953		20	295	295	664	26
27 Roof Repairs	2002	11,473		20	1,147	1,147	2,486	27
28 Shower Base	2002	1,608		20	161	161	429	28
29 Shower Repairs	2002	900		20	90	90	255	29
30 Shower Stall Installation	2002	990		20	99	99	289	30
31 Sprinkler And Pipe Repairs	2002	3,835		20	384	384	991	31
32 Sprinkler And Repairs	2002	6,430		20	643	643	1,500	32
33 Thermostat	2002	755		20	76	76	208	33
34 TOTAL (lines 1 thru 33)		\$ 1,467,550	\$ 68,729		\$ 52,134	\$ (16,595)	\$ 903,069	34

<sup>\*\*</sup>Improvement type must be detailed in order for the cost report to be considered complete.

Page 12E 12/31/04 Facility Name & ID Number Sacred Heart Home Inc. # 001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar. # 0013334 Report Period Beginning: 01/01/04 Ending:

B. Building Depreciation-Including Fixed Equipmen	3	4	5	6	7	8	9	
	Year		Current Book	Life	Straight Line		Accumulated	
Improvement Type**	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
1 Totals from Page 12D, Carried Forward		s 1,467,550	\$ 68,729		\$ 52,134	\$ (16,595)	\$ 903,069	1
2 Thermostat	2002	551		20	55	55	133	2
3 Tuckpointing	2002	13,900		20	1,390	1,390	3,359	3
4 Vent Repairs	2002	545		20	55	55	159	4
5 Vertical Blinds	2002	870		20	87	87	210	5
6 Wallpaper	2002	2,834		20			2,834	6
7 Welding Repairs	2002	869		20	87	87	224	7
8 Radiator Repairs	2003	2,129		20	213	213	426	8
9 Painting	2003	580		20	58	58	116	9
10 Hallway Repairs	2003	667		20	67	67	133	10
11 Fence Painting Supplies	2003	1,156		20	116	116	231	11
12 Bathroom/Shower Repairs	2003	2,325		20	233	233	465	12
13 Painting	2003	1,014		20	101	101	194	13
14 Stem Trap Installation	2003	1,389		20	139	139	266	14
15 Pump Installation	2003	2,187		20	219	219	401	15
16 Valve Repairs	2003	1,825		20	183	183	335	16
17 Wiring Pump Motor	2003	815		20	82	82	149	17
18 Painting	2003	575		20	58	58	101	18
19 Vertical Blinds	2003	1,196		20	120	120	209	19
20 Metal Screen Repairs	2003	1,601		20	160	160	280	20
21 Parking Lot Repairs	2003	15,500		20	1,550	1,550	2,583	21
22 Painting	2003	770		20	77	77	128	22
23 Rear Door Mounts	2003	968		20	97	97	161	23
24 Electrical Installation	2003	14,804		20	1,480	1,480	2,344	24
25 Switch Installation	2003	2,775		20	278	278	486	25
26 Elevator Repairs	2003	3,998		20	400	400	500	26
Wiring In Business Office	2003	2,175		20	218	218	254	27
28 Cooler/Pipe Repairs	2003	3,800		20	380	380	443	28
29 Roof Repairs	2003	3,700		20	370	370	432	29
30 Roof Repairs	2003	14,500		20	1,450	1,450	1,571	30
31 Metal Doors	2003	755		20	76	76	82	31
32 Driveway	2003	2,690		20	269	269	291	32
33 Smoking Room Materials	2003	975		20	98	98	106	33
34 TOTAL (lines 1 thru 33)		\$ 1,571,988	\$ 68,729		\$ 62,300	\$ (6,429)	\$ 922,675	34

<sup>\*\*</sup>Improvement type must be detailed in order for the cost report to be considered complete.

Page 12F 12/31/04 Facility Name & ID Number Sacred Heart Home Inc. # 001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment, (See instructions.) Round all numbers to nearest dollar. # 0013334 Report Period Beginning: 01/01/04 Ending:

B. Building Depreciation-Including Fixed Equipme	3	4	5	6	1 7	. 8	9	
<u>.</u>	Year	•	Current Book	Life	Straight Line		Accumulated	
Improvement Type**	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
1 Totals from Page 12E, Carried Forward	Constructed	\$ 1,571,988	\$ 68,729	m rears	s 62,300	\$ (6,429)	\$ 922,675	1
2 Vertical Blinds	2003	2,719	00,12	20	272	272	453	2
3 Sign Board	2003	800		20	80	80	120	3
4 Air Conditioners	2003	4,148		20	415	415	622	4
5 Valve Repairs	2003	514		20	51	51	81	5
6 Sprinkler Repairs	2003	573		20	57	57	91	6
7 Repair Freon Leaks	2003	1,506		20	151	151	201	7
8 Pull Station Repairs	2003	573		20	57	57	76	8
9 Boiler Repairs	2003	510		20	51	51	64	9
10 Condensor Pump Repairs	2003	695		20	70	70	87	10
11 Pump Repairs	2003	1,156		20	116	116	125	11
12 Door	2003	736		20	74	74	141	12
13 Office Renovations	2003	635		20	64	64	122	13
14 Hallway Repairs	2003	2,036		20	204	204	373	14
15 Utility Room Renovations	2003	1,057		20	106	106	167	15
16 Drive Gate	2003	2,045		20	205	205	307	16
17 Pump Installation	2003	2,870		20	287	287	407	17
18 Roofing Repairs	2003	1,500		20	150	150	200	18
19 Smoking Room Renovations	2003	4,867		20	487	487	568	19
20 Bathroom Repairs	2003	4,082		20	408	408	646	20
21 Fence/Gate Installation	2003	1,278		20	128	128	224	21
22 Parking Lot	2003	2,850		20	285	285	451	22
23 Laundry/Physicain Office Repairs	2003	1,008		20	101	101	134	23
24 Motor	2003	680		20	68	68	91	24
25 Business Office/Utility Room Renovation	2003	6,511		20	651	651	760	25
26 Fence/Gate Repairs	2003	764		20	76	76	89	26
27 Parking Lot Repairs	2003	1,000		20	100	100	108	27
28 Bathroom Renovations	2003	1,204		20	120	120	130	28
29 Land Improvements	2003	2,800		20	280	280	420	29
30 Light Fixtures	2003	613		20	61	61	92	30
31 Office/Bathroom Renovation	2003	2,266		20	227	227	283	31
32 Door Repair	2003	2,045		20	205	205	256	32
33 Fence	2004	12,580	60.500	20	629	629	629	33
34 TOTAL (lines 1 thru 33)	1	s 1,640,609	\$ 68,729		\$ 68,536	s (193)	\$ 931,193	34

<sup>\*\*</sup>Improvement type must be detailed in order for the cost report to be considered complete.

Page 12G 12/31/04 Facility Name & ID Number Sacred Heart Home Inc. # 001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment, (See instructions.) Round all numbers to nearest dollar. # 0013334 Report Period Beginning: 01/01/04 Ending:

Totals from Page 12F, Carried Forward   S 1,640,669   S 68,729   S 68,536				3		4	5	6	7		8		9	
Totals from Page 12F, Carried Forward   S 1,640,609   S 68,729   S 68,536     Metal Fire Doors*   2004   5338   20 54     Fire Eacape Repairs   2004   5,000   20 375     Plumbing Repairs   2004   23,293   20 1,165     Roof Repairs*   2004   1,000   20 50     Roof Repairs*   2004   30,000   20 1,500     Roof Repairs*   2004   30,000   20 1,500     Roof Repairs*   2004   2,065   20 103     Stainless Steel Car Station*   2004   2,065   20 103     Wallguards*   2004   780   20 20 26     Pump*   2004   780   20 20 39     Pump*   2004   22,144   20 1,409     Pump*   2004   28,174   20 1,409     Pire System Upgrade*   2004   12,345   20 0 617     Fire Panel Repairs   2004   693   20 35     Fire Panel Repairs   2004   645   20 32     Wallguards*   2004   550   20 35     Wallguards*   2004   550   20 35     Wallguards*   2004   550   20 32     Light Fixtures   2004   550   20 28     Light Fixtures   2004   570   20 34     Light Fixtures   2004   570   20 34     Painting Materials   2004   2,059   20 35     Painting Materials   2004   2,059   20 34     Painting Materials   2004   6,75   20 34     Painting Materials   2004   2,059   20 34     Painting Materials   2004   6,75   20 34     Painting Materials   2004   2,059   20 34     Painting Materials   2,004   2,059   20 34     Pump*													Accumulated	
Metal Fire Doors*   2004   538   20   54				Constructed				ears			Adjustments		Depreciation	
Second Repairs   2004   5,000   20   375	ed	d Forward			\$	, , , , , , , ,	\$ 68,729			\$	(193)	\$	931,193	1
Plumbing Repairs   2004   23,293   20   1,165				2004		538		20			54		54	2
Plumbing Repairs   2004   23,293   20   1,165				2004		5,000		20	375		375		375	3
Roof Repairs   2004   30,000   20   1,500				2004		23,293		20	1,165		1,165		1,165	4
6 Roof Repairs*       2004       30,000       20       1,500         8 Wallquards*       2004       518       20       26         9 Elevator Repairs*       2004       780       20       39         10 Pump*       2004       922       20       46         11 Activit/Utility/Exam Room Repairs*       2004       28,174       20       1,409         12 Fire System Upgrade*       2004       8,915       20       617         13 Fire Panel Repairs       2004       893       20       35         14 Fire System Repairs       2004       693       20       35         15 Fire Panel Repairs       2004       693       20       35         16 Elevator Repairs       2004       645       20       35         16 Elevator Repairs       2004       645       20       32         17 Light Fixtures       2004       645       20       32         18 Light Fixtures       2004       550       20       28         19 Wallguards       2004       550       20       28         19 Wallguards       2004       550       20       28         20 Painting Materials       2004       670       <				2004		1,000		20	50		50		50	5
Wallguards   2004   518   20   26				2004		30,000		20	1,500		1,500		1,500	(
Elevator Repairs   2004   780   20   39						2,065		20	103		103		103	1
Description   Pump*   2004   922   20   46											26		26	8
Activity/Utility/Exam Room Repairs*   2004   28,174   20   1,409											39		39	3
Fire System Upgrade*   2004   12,345   20   617											46		46	1
Simple   S	R	Repairs*							,		1,409		1,409	1
Fire System Repairs   2004   693   20   35											617		617	1
Sample   State   Sta											446		446	1
6 Elevator Repairs 2004 645 20 32 7 Light Fixtures 2004 550 20 28 8 Light Fixtures 2004 550 20 28 9 Wallguards 2004 1,059 20 53 0 Painting Materials 2004 670 20 34 1 Fire Alarm Repairs 2004 9,378 20 469 2 Fire Extinguisher Installation 2004 2,059 20 103 3 Cove Base 2004 528 20 26 4 Boiler Installation 2004 10,330 20 517 5 Fence Repairs 2004 675 20 34 8 Simoking Room Renovations* 2004 12,283 20 614 8 Fire Repairs 2004 12,283 20 614 8 Fire Repairs 2004 12,283 20 614 8 Fire Repairs 2004 12,283 20 614 8 Fire Repairs 2004 12,283 20 614											35		35	1
Light Fixtures   2004   550   20   28     Light Fixtures   2004   550   20   28     Wallguards   2004   1,059   20   53     Painting Materials   2004   670   20   34     Fire Alarm Repairs   2004   9,378   20   469     Fire Extinguisher Installation   2004   528   20   26     Boiler Installation   2004   10,330   20   517     Fence Repairs   2004   675   20   34     Boiler Installation   2004   10,330   20   517     Fence Repairs   2004   675   20   34     Fire Stringuisher Installation   2004   10,330   20   517     Fence Repairs   2004   675   20   34     Fire In 6/30/04 Capital Report   2004   12,283   20   614     Fire In 6/30/04 Capital Report   2004   2004   2004   2004   2004     Fire Stringuisher Installation   2004   2004   2004   2004   2004     Fire Stringuisher Installation   2004											26		26	1
State Fixtures   2004   550   20   28											32		32	1
Wallguards   2004   1,059   20   53											28		28	1
Painting Materials   2004   670   20   34     Fire Alarm Repairs   2004   9,378   20   469     Fire Extinguisher Installation   2004   2,059   20   103     Cove Base   2004   528   20   26     Boiler Installation   2004   10,330   20   517     Fence Repairs   2004   675   20   34     Smoking Room Renovations*   2004   12,283   20   614     Terms In 6/30/04 Capital Report   2004   2004   2004     Coverage   2004   2,059   20   20          Covera											28		28	1
Fire Alarm Repairs   2004   9,378   20   469											53		53	1
Fire Extinguisher Installation   2004   2,059   20   103     Cove Base   2004   528   20   26     Boiler Installation   2004   10,330   20   517     Fence Repairs   2004   675   20   34     6 Smoking Room Renovations*   2004   12,283   20   614     7 * Items In 6/30/04 Capital Report   2004   20     8   9                       1											34		34	2
Cove Base   2004   528   20   26											469		469	2
Boiler Installation   2004   10,330   20   517     Fence Repairs   2004   675   20   34     Smoking Room Renovations*   2004   12,283   20   614     **Tems In 6/30/04 Capital Report   2004   2004     04     **Tems In 6/30/04 Capital Report   2004   20	1	1									103		103	2
Second Fence Repairs   2004   675   20   34											26		26	2
6 Smoking Room Renovations* 2004 12,283 20 614 7 * Items In 6/30/04 Capital Report 2004 8											517		517	2
7 * Items In 6/30/04 Capital Report 2004 20 8 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9	_				<u> </u>					_	34	_	34	2
8 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9					<u> </u>	12,283			614	_	614	_	614	2
9	p	port		2004	-			20		_		-		
0	_				-					_		-		2
1 2										4		-		3
					<u> </u>		ļ			╄		+		3
										+		1		3
2										+		1		3
3   4   TOTAL (lines 1 thru 33)   \$ 1.794.090   \$ 68.729   \$ 76.362			-		6	1 704 000	6 (9.730		6 76 363	s	7,633	S	939,020	3

<sup>\*\*</sup>Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Sacred Heart Home Inc.

XI. OWNERSHIP COSTS (continued)

# 0013334

Report Period Beginning:

76,362

7,633

01/01/04 Ending:

Page 12H 12/31/04

939,020

34

34 TOTAL (lines 1 thru 33)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar. Straight Line Depreciation Year **Current Book** Life Accumulated Improvement Type\*\* Constructed Cost Depreciation in Years Adjustments Depreciation 1 Totals from Page 12G, Carried Forward 1,794,090 68,729 76,362 7,633 939,020 3 4 5 6 7 8 9 10 10 11 11 12 13 14 12 13 14 15 16 17 15 16 17 18 18 19 19 20 21 20 21 22 23 24 25 22 23 24 25 26 26 27 27 28 28 29 30 30 31 31 32 32

1,794,090

SEE ACCOUNTANTS' COMPILATION REPORT

68,729

<sup>\*\*</sup>Improvement type must be detailed in order for the cost report to be considered complete.

# 0013334

Report Period Beginning:

01/01/04 Ending:

Page 12I 12/31/04

I	3	4	5	6	7	8	9	
	Year		Current Book	Life	Straight Line Depreciation		Accumulated	
Improvement Type**	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
1 Totals from Page 12H, Carried Forward		s 1,794,090	\$ 68,729		<b>\$</b> 76,362	\$ 7,633	\$ 939,020	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16 17								16 17
17								18
19								19
20								20
21							+	21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33		4 50 4 000	60 500					33
34 TOTAL (lines 1 thru 33)		\$ 1,794,090	\$ 68,729		\$ 76,362	\$ 7,633	\$ 939,020	34

 $<sup>{\</sup>rm **Improvement\ type\ must\ be\ detailed\ in\ order\ for\ the\ cost\ report\ to\ be\ considered\ complete}.$ 

Page 12J 12/31/04

R Ruilding Denreciation	n-Including Fixed Equi	inment (See instructions )	Round all numbers to nearest dolls	ar

1	3		4	5	6	7	8	9	$\neg$
	Year			Current Book	Life	Straight Line		Accumulated	
Improvement Type**	Constructed		Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
1 Totals from Page 12I, Carried Forward		s 1	,794,090	\$ 68,729		\$ 76,362	\$ 7,633	\$ 939,020	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12 13
14									13
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28 29									28 29
30									30
31									31
32									32
33		1							33
34 TOTAL (lines 1 thru 33)		<b>\$</b> 1	,794,090	\$ 68,729		\$ 76,362	s 7,633	s 939,020	34

<sup>\*\*</sup>Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Sacred Heart Home Inc.

XI. OWNERSHIP COSTS (continued)

# 0013334

Report Period Beginning:

01/01/04 Ending:

7,633

76,362

Page 12K 12/31/04

939,020

34

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

34 TOTAL (lines 1 thru 33)

I	3	4	5	6	7	8	9	T
	Year		Current Book	Life	Straight Line		Accumulated	
Improvement Type**	Constructed	Cost	Depreciation	in Years	Straight Line Depreciation	Adjustments	Depreciation	
1 Totals from Page 12J, Carried Forward		<b>\$</b> 1,794,090	\$ 68,729		\$ 76,362	\$ 7,633	\$ 939,020	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13 14
15								15
16	_							16
17				-				17
18								18
19								19
20				İ				20
21								21
22								22
23								23
24								24
25			_		_			25
26								26
27							`	27
28								28
29								29
30								30
31 32				1				31 32
33				1				33
24 TOTAL (lines 1 thus 22)		6 1 704 000	c 69.720		e 76.363	e 7.622	6 030 030	33

1,794,090

SEE ACCOUNTANTS' COMPILATION REPORT

68,729

<sup>\*\*</sup>Improvement type must be detailed in order for the cost report to be considered complete.

Page 12-BLDG 12/31/04 STATE OF ILLINOIS Facility Name & ID Number Sacred Heart Home Inc. # 001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment, (See instructions.) Round all numbers to nearest dollar. # 0013334 Report Period Beginning: 01/01/04 Ending:

	1		2	3	4	5	6	7	8	9	
		FOR OHF USE ONLY	Year	Year		Current Book	Life	Straight Line		Accumulated	
	Beds*		Acquired	Constructed	Cost	Depreciation	in Years	Straight Line Depreciation	Adjustments	Depreciation	
4			1971	1971	s 140,000	\$		\$	\$	\$ 140,000	4
5											5
6											6
7											7
8											8
	Impro	ovement Type**									
9											9
10											10
11		_	•								11
12											12
13											13
14											14
15											15
16											16
17 18											17
19											18 19
20											20
21											21
22											22
23											23
24											24
25											25
26				1				İ			26
27				1							27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35		_	•								35
36			·					1			36

<sup>\*\*</sup>Improvement type must be detailed in order for the cost report to be considered complete.

STATE OF ILLINOIS

Page 12A-BLDG 12/31/04 Facility Name & ID Number Sacred Heart Home Inc.

XI. OWNERSHIP COSTS (continued) # 0013334 Report Period Beginning: 01/01/04 Ending:

B. Building Depreciation-Including Fixed Equ	uipment. (See instructions.) Roun	d all numbers to nea	rest dollar.					
1	3	4	5	6	7	8	9	
	Year		Current Book	Life	Straight Line Depreciation		Accumulated	
Improvement Type**	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70 TOTAL (lines 4 thru 69)		\$ 140,000	\$		<b>S</b>	\$	\$ 140,000	70

<sup>\*\*</sup>Improvement type must be detailed in order for the cost report to be considered complete.

STATE OF ILLINOIS

Page 12-REP 12/31/04 Facility Name & ID Number Sacred Heart Home Inc. # 001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar. # 0013334 Report Period Beginning: 01/01/04 Ending:

	1	ing Depreciation-Including Fixed Eq	2	3	4	5	6	7	8	9	_
		FOR OHF USE ONLY	Year	Year	•	Current Book	Life	Straight Line		Accumulated	
	Beds*	TOR OIL USE OILE	Acquired	Constructed	Cost	Depreciation	in Years	Depreciation 1	Adjustments	Depreciation	
4		IADO Management	1988		\$ 48,426	\$ 1,761		\$ 1,384		\$ 12,452	4
5	ranocated in		1700	1500	,.20	2,701		1,001	(611)	12,102	5
6											6
7											7
8											8
	Impr	ovement Type**									
9		IADO Management		1995	1,123	224	20	56	(168)	534	9
10	Allocated M	IADO Management		1993	18,446	491	20	922	431	10,536	10
11	Allocated M	ADO Management		2000	2,759	-	20	138	138	624	11
12	Allocated M	ADO Management		2001	1,195	19	20	60	(41)	223	12
		IADO Management		2002	1,880	-	20	170	170	463	13
	Allocated M	ADO Management		2004	365	-	20	6	6	6	14
15											15
16											16
17											17
18											18
19											19
20											20 21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33				_							33
34											34
35											35
36	l										36

<sup>\*\*</sup>Improvement type must be detailed in order for the cost report to be considered complete.

Page 12A-REP 12/31/04 STATE OF ILLINOIS Facility Name & ID Number Sacred Heart Home Inc. # 001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar. # 0013334 Report Period Beginning: 01/01/04 Ending:

B. Building Depreciation-Including Fixed Equip	3	4	5	6	7	8	9	
	Year		Current Book	Life	Straight Line		Accumulated	
Improvement Type**	Constructed	Cost	Depreciation	in Years	Straight Line Depreciation	Adjustments	Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51   52								51
53								52 53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70 TOTAL (lines 4 thru 69)		s 74,194	\$ 2,495		\$ 2,736	s 159	\$ 24,838	70

<sup>\*\*</sup>Improvement type must be detailed in order for the cost report to be considered complete.

STA	TE	OF	HI	INOIS

Page 13 Facility Name & ID Number Sacred Heart Home Inc. 0013334 **Report Period Beginning:** 01/01/04 12/31/04 **Ending:** 

## XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of	1 1 C		Current Book	Straight Line 4		Component	Accumulated	
	Equipment	Cost		Depreciation 2	Depreciation 3	Adjustments	Life 5	Depreciation 6	
71	Purchased in Prior Years	\$ 252,887		\$ 15,001	\$ 18,349	\$ 3,348	10	\$ 174,466	71
72	Current Year Purchases	17,345		8,808	1,405	(7,403)	10	1,405	72
73	Fully Depreciated Assets	80,810					10	80,810	73
74									74
75	TOTALS	\$ 351,042		\$ 23,809	\$ 19,754	\$ (4,055)		\$ 256,681	75

D. Vehicle Depreciation (See instructions.)\*

	1	Model, Make	Year	4	Current Book	Straight Line	7	Life in	Accumulated	
	Use	and Year 2	Acquired 3	Cost	Depreciation 5	Depreciation 6	Adjustments	Years 8	Depreciation 9	
76		1997 JEEP GRAND CHER	1998	\$ 24,457	\$ 1,775	\$	\$ (1,775)	5	\$ 24,456	76
77	<u> </u>									77
78	<u> </u>									78
79										79
80	TOTALS			\$ 24,457	\$ 1,775	\$	\$ (1,775)		\$ 24,456	80

	E. Summary of Care-Related Assets	1	2		
		Reference	Amount		J
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 2,191,666	81	Ī
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 94,313	82	1
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 96,116	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 1,803	84	1
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,220,156	85	1

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1	2	2	Current Book		Accumulated	
	Description & Year Acquired	Co	st	Depreciation	3	Depreciation 4	
86	BOILER REPAIR - 1997	\$	2,297	\$		\$	86
87							87
88							88
89							89
90							90
91	TOTALS	\$	2,297	\$		\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

SEE ACCOUNTANTS' COMPILATION REPORT

\*\* This must agree with Schedule V line 30, column 8.

Facil	ity Name & II	D Number	Sacro	ed Heart Home	Inc.		STA #	TE OF ILLINOIS 0013334		rt Period l	Beginning:	01/01/04	Ending:	Page 14 12/31/04
	1. Name of I 2. Does the f	nd Fixed Equ Party Holding	Lease: ` y real esta	ee instructions.  N/A  ate taxes in add	_	amount shown below o	on line 7,		]NO					
		1 Year Constructe	ed	2 Number of Beds	3 Original Lease Date	4 Rental Amount		5 Total Years of Lease	6 Total Years Renewal Option	k				
3 4 5 6	Original Building: Additions			0.200		\$ \$		O. Democ	Tellerian Space	3 4 5 6	Beginning Ending	lates of current e paid in future eement:	<u> </u>	
	This amou	unt was calcul ngth of the lea	lated by di	of lease expens ividing the tota	l amount to be			*			Fiscal Year 12. 13.	/2005 /2006 /2007	Annual Res	nt
	15. Îs Moval	ble equipment amount for m	t rental ind ovable equ	ntion and Fixed cluded in build nipment: \$	ing rental?	See instructions.) Description	n: See	Attached Schedule	NO e detailing the bre	akdown of	f movable equipm	nent)		
17 18	1 Use	Same (See Inst	Mo	2 odel Year nd Make	\$	3 Monthly Lease Payment	\$	4 Rental Expense for this Period	17			is an option to l		
19 20	TOTAL				\$		\$		19 20 21		** This am	ount plus any a must agree wit		

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sacred Heart Home In	ıc.			#	0013334	Report Period Beginning:	01/01/04	Ending:	12/31/04
XIII. EXPENSES RELATING TO NURSE AIDE TRAINING	PROGRAMS (See in	structions.)							
A. TYPE OF TRAINING PROGRAM (If aides are traine	d in another facility	nrogram, attach a	schedule listing t	the facility	name, addre	ss and cost ner aide trained in t	nat facility.)		
The first the first transfer of the first tr	a in unother facility	program, accaen a	senedule listing t	ine memej	nume, udure	ss and cost per aide trained in the	int incliney.)		
1. HAVE YOU TRAINED AIDES DURING THIS REPORT	YES 2.	. <u>CLASSROOM</u>	PORTION:			3. CLINICAL PO	RTION:	_	
PERIOD?	X NO	IN-HOUSE PR	ROGRAM			IN-HOUSE PR	OGRAM		
		IN OTHER FA	CILITY			IN OTHER FA	CILITY		
If "yes", please complete the remainder of this schedule. If "no", provide an		COMMUNITY	COLLEGE			HOURS PER A	AIDE		
explanation as to why this training was not necessary.		HOURS PER A	AIDE						
B. EXPENSES	ALLOCATI	ON OF COSTS	(d)			C. CONTRACTUAL I	NCOME		
	ALLOCATI	ON OF COSTS	(u)			In the box belo	w record the	mount of ir	come vour
	1	2	3		4	facility received			
	Fa	cility				· ·	Ü		
	Drop-outs	Completed	Contract		Total	\$			
1   Community College Tuition	\$	\$	\$	\$					
2 Books and Supplies						D. NUMBER OF AIDE	S TRAINED		
3 Classroom Wages (a)									
4 Clinical Wages (b)						COMPLET	ΓED		
5 In-House Trainer Wages (c)						1. From this fac	cility		
6 Transportation						2. From other f	acilities (f)		
7 Contractual Payments					•	DROP-OU	TS		
8 Nurse Aide Competency Tests						1. From this fac	cility		

\$

\$

STATE OF ILLINOIS

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.

(e)

TOTALS

SUM OF line 9, col. 1 and 2

(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.

2. From other facilities (f)

TOTAL TRAINED

Page 15

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Page 16 Report Period Beginning: 01/01/04 **Ending:** 12/31/04

## XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	(	1	2	3	4	5	6	7	8	
		Schedule V	Stafi		Outsid	e Practitioner	Supplies			
	Service	Line & Column	Units of	Cost	(other tl	nan consultant)	(Actual or)	Total Units	Total Cost	
		Reference	Service		Units	Cost	Allocated)	(Column 2 + 4)	(Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
	Licensed Speech and Language	N/A								
2	Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
			# of							
9	Pharmacy		prescrpts							9
	Psychological Services									
	(Evaluation and Diagnosis/									
10	Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental									13
14	TOTAL			\$		\$	\$		\$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Sacred Heart Home Inc.

As of 12/31/04 (last day of reporting year)

XV. BALANCE SHEET - Unrestricted Operating Fund.

This report must be completed even if financial statements are attached.

		10	perating	2 After Consolidation		
	A. Current Assets					
1	Cash on Hand and in Banks	\$	(747)	\$	(747)	1
2	Cash-Patient Deposits		13,441		13,441	2
	Accounts & Short-Term Notes Receivable-					
3	Patients (less allowance )		478,880		500,957	3
4	Supply Inventory (priced at )					4
5	Short-Term Investments					5
6	Prepaid Insurance		39,331		39,331	6
7	Other Prepaid Expenses					7
8	Accounts Receivable (owners or related parties)		3,256,767		5,145,633	8
9	Other(specify): See Attached Schedule		15,535		15,535	9
	TOTAL Current Assets					
10	(sum of lines 1 thru 9)	\$	3,803,207	\$	5,714,150	10
	B. Long-Term Assets					
11	Long-Term Notes Receivable					11
12	Long-Term Investments					12
13	Land					13
14	Buildings, at Historical Cost				140,000	14
15	Leasehold Improvements, at Historical Cost		1,312,731		1,312,731	15
16	Equipment, at Historical Cost		353,182		368,182	16
17	Accumulated Depreciation (book methods)		(1,017,921)		(1,172,921)	17
18	Deferred Charges					18
19	Organization & Pre-Operating Costs					19
	Accumulated Amortization -					
20	Organization & Pre-Operating Costs					20
21	Restricted Funds					21
22	Other Long-Term Assets (specify):					22
23	Other(specify): See Attached Schedule					23
	TOTAL Long-Term Assets					
24	(sum of lines 11 thru 23)	\$	647,992	\$	647,992	24
	TOTAL ASSETS					
25	(sum of lines 10 and 24)	\$	4,451,199	\$	6,362,142	25

		1	perating	C		
	C. Current Liabilities					
26	Accounts Payable	\$	266,139	\$	326,105	26
27	Officer's Accounts Payable					27
28	Accounts Payable-Patient Deposits					28
29	Short-Term Notes Payable					29
30	Accrued Salaries Payable		23,652		23,652	30
	Accrued Taxes Payable					
31	(excluding real estate taxes)					31
32	Accrued Real Estate Taxes(Sch.IX-B)				3,362	32
33	Accrued Interest Payable					33
34	Deferred Compensation					34
35	Federal and State Income Taxes					35
	Other Current Liabilities(specify):					
36	See Attached Schedule					36
37						37
	TOTAL Current Liabilities					
38	(sum of lines 26 thru 37)	\$	289,791	\$	353,119	38
	D. Long-Term Liabilities					
39	Long-Term Notes Payable					39
40	Mortgage Payable					40
41	Bonds Payable					41
42	Deferred Compensation					42
	Other Long-Term Liabilities(specify):					
43	See Attached Schedule					43
44						44
	TOTAL Long-Term Liabilities					
45	(sum of lines 39 thru 44)	\$		\$		45
	TOTAL LIABILITIES					
46	(sum of lines 38 and 45)	\$	289,791	\$	353,119	46
	, , , , , , , , , , , , , , , , , , ,				ĺ	
47	TOTAL EQUITY(page 18, line 24)	\$	4,161,408	\$	6,009,023	47
	TOTAL LIABILITIES AND EQUITY					
48	(sum of lines 46 and 47)	\$	4,451,199	\$	6,362,142	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

1 Total 1 Balance at Beginning of Year, as Previously Reported 4,264,296 1 2 Restatements (describe): 2 3 Expense Restatement (7,122)3 4 Income Restatement (52,805)4 5 6 Balance at Beginning of Year, as Restated (sum of lines 1-5) 6 4,204,369 A. Additions (deductions): 7 NET Income (Loss) (from page 19, line 43) (42,961) 7 8 Aquisitions of Pooled Companies 8 9 Proceeds from Sale of Stock 9 10 Stock Options Exercised 10 11 Contributions and Grants 11 12 Expenditures for Specific Purposes 12 13 Dividends Paid or Other Distributions to Owners 13 14 Donated Property, Plant, and Equipment 14 15 Other (describe) 15 16 Other (describe) 16 17 TOTAL Additions (deductions) (sum of lines 7-16) 17 (42,961)B. Transfers (Itemize): 18 18 19 19 20 20 21 21 22 22 23 TOTAL Transfers (sum of lines 18-22) 23 24 BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23) 24 4,161,408

<sup>\*</sup> This must agree with page 17, line 47.

01/01/04

**Report Period Beginning:** 

4 Ending:

Page 19 12/31/04

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1

	Revenue		Amount	
	A. Inpatient Care		Amount	
1	Gross Revenue All Levels of Care	S	4,678,727	1
2	Discounts and Allowances for all Levels	(	1,070,727	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	S	4,678,727	3
	B. Ancillary Revenue	Ψ.	1,070,727	
4	Day Care			4
5	Other Care for Outpatients			5
6	Therapy			6
7	Oxygen			7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$		8
	C. Other Operating Revenue			
9	Payments for Education			9
10	Other Government Grants			10
11	Nurses Aide Training Reimbursements			11
12	Gift and Coffee Shop		78,849	12
13	Barber and Beauty Care			13
14	Non-Patient Meals			14
15	Telephone, Television and Radio			15
16	Rental of Facility Space			16
17	Sale of Drugs			17
18	Sale of Supplies to Non-Patients			18
19	Laboratory			19
20	Radiology and X-Ray			20
21	Other Medical Services			21
22	Laundry			22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	78,849	23
	D. Non-Operating Revenue			
24	Contributions			24
	Interest and Other Investment Income***			25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$		26
	E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)			27
28	See Supplemental Schedule			28
28a				28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$		29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$	4,757,576	30

		2	
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,546,609	31
32	Health Care	1,544,673	32
33	General Administration	1,224,371	33
	B. Capital Expense		
34	Ownership	286,527	34
	C. Ancillary Expense		
35	Special Cost Centers	103,929	35
36	Provider Participation Fee	94,428	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,800,537	40
41	Income before Income Taxes (line 30 minus line 40)**	(42,961)	41
41	income before income Taxes (nne 30 minus nne 40)	(42,901)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (42,961)	43

- \* This must agree with page 4, line 45, column 4.
- \*\* Does this agree with taxable income (loss) per Federal Income
  Tax Return? Not Complete If not, please attach a reconciliation.
- \*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT
- \*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

		1	2**	3	4				
		# of Hrs.	# of Hrs.	Reporting Period	Average				Nı
		Actually	Paid and	Total Salaries,	Hourly				0
		Worked	Accrued	Wages	Wage				P
1	Director of Nursing			\$	\$	1			Ac
2	Assistant Director of Nursing					2	35	Dietary Consultant	
3	Registered Nurses	529	545	12,193	22.37	3	30	Medical Director	Moi
4	Licensed Practical Nurses	3,740	3,940	71,174	18.06	4	37	Medical Records Consultant	Moi
- 5	Nurse Aides & Orderlies	62,976	68,391	540,499	7.90	5	38	Nurse Consultant	
6	Nurse Aide Trainees					6	39	Pharmacist Consultant	
7	Licensed Therapist					7	40	Physical Therapy Consultant	
8	Rehab/Therapy Aides					8	41	Occupational Therapy Consultant	
9	Activity Director	520	528	6,336	12.00	9	42	Respiratory Therapy Consultant	
10	Activity Assistants	16,685	17,638	106,857	6.06	10	43	Speech Therapy Consultant	
11	Social Service Workers	13,888	14,763	137,701	9.33	11	44	Activity Consultant	
12	Dietician	3,711	4,084	28,334	6.94	12	45	Social Service Consultant	
13	Food Service Supervisor	,		, and the second second		13	40	Other(specify) Dietary-Outside La	$\top$
14	Head Cook					14	47		
15	Cook Helpers/Assistants	25,575	28,260	202,064	7.15	15	48	Activity - Outside Labor	$\top$
16	Dishwashers	,	ĺ	,		16			
17	Maintenance Workers	15,647	16,896	169,999	10.06	17	49	TOTAL (lines 35 - 48)	
18	Housekeepers	39,819	43,819	292,832	6.68	18		, ,	
19	Laundry					19			
20	Administrator					20			
21	Assistant Administrator	529	545	11,667	21.41	21	C.	CONTRACT NURSES	
22	Other Administrative			,		22			
23	Office Manager					23			N
24	Clerical	1,523	1,853	43,983	23.74	24			0
25	Vocational Instruction	,		, and the second second		25			P
26	Academic Instruction					26			A
27	Medical Director					27	50	Registered Nurses	$\top$
28	Qualified MR Prof. (QMRP)					28	51	Licensed Practical Nurses	
29	Resident Services Coordinator					29	52	Nurse Aides	$\top$
30	Habilitation Aides (DD Homes)					30			$\top$
31	Medical Records					31	53	3 TOTAL (lines 50 - 52)	
32	Other Health Care(specify)					32		- '	
33	Other(specify) See Supplemental					33			
34	TOTAL (lines 1 - 33)	185,142	201,262	s 1,623,639 *	\$ 8.07	34	SEE AC	COUNTANTS' COMPILATION REP	ORT

## B. CONSULTANT SERVICES

		1	2	3	
		Number	<b>Total Consultant</b>	Schedule V	
		of Hrs.	Cost for	Line &	
		Paid &	Reporting	Column	
		Accrued	Period	Reference	
35	Dietary Consultant	280	\$ 8,207	01-03	35
36	Medical Director	Monthly	2,000	09-03	36
37	Medical Records Consultant	Monthly	2,752	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	55	2,520	11-03	44
45	Social Service Consultant	117	6,524	12-03	45
46	Other(specify) Dietary-Outside La	3,236	49,710	01-03	46
47	Social Service - Outside Labor	4,653	66,312	12-03	47
48	Activity - Outside Labor	2,453	22,803	11-03	48
49	TOTAL (lines 35 - 48)	10,794	s 160,828		49

## C. CONTRACT NURSES

		1	2	3	
		Number		Schedule V	
		of Hrs.	Total	Line &	
		Paid &	Contract	Column	
		Accrued	Wages	Reference	
50	Registered Nurses	13,156	s 344,302	10-03	50
51	Licensed Practical Nurses	7,178	161,235	10-03	51
52	Nurse Aides	549	12,157	10-03	52
53	TOTAL (lines 50 - 52)	20,883	\$ 517,694		53

<sup>\*</sup> This total must agree with page 4, column 1, line 45.

<sup>\*\*</sup> See instructions.

STATE OF ILLINOIS	
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Facility Name & ID Number		Inc.			# 0013334		Repo	ort Period Beg	inning:	01/01/04	Ending:	12/31/0
XIX. SUPPORT SCHEDULE	ES								In n		- I D	
A. Administrative Salaries Name	Function	Ownership %	p	Amount	D. Employee Benefits and Payrol			A 4	F. Dues, F	Fees, Subscriptions an Description	ia Promotion	ıs Amour
			e		Description		•	Amount	IDDII I			Amour S
Mardy Gibbs	Asst. Admin	None	\$_	11,667	Workers' Compensation Insuran		ъ_	30,240	IDPH Lic			
	<u> </u>		_		Unemployment Compensation In	isurance	_	44,133		ng: Employee Recrui		14,1
	<u> </u>		_		FICA Taxes Employee Health Insurance		_	124,208		re Worker Backgrou		3
	<u> </u>		-		F - 7			2,028	`	# of checks performe	ed <u>27</u> )	
					Employee Meals			38,796	Licenses a			1,7
			_		Illinois Municipal Retirement Fu	nd (IMRF)*	_			g and Promotion		1,5
	<del>_</del> , <del></del>		_		401K Expenses		_	65	Alloc-MA	DO Management		1,3
TOTAL (agree to Schedule V					_		_					
(List each licensed administra	ator separately.)			11,667								
B. Administrative - Other												
										blic Relations Expen		
Description				Amount						n-allowable advertisi		(1,5
Management Fees - MADO M	Management		\$_	668,000					Yel	low page advertising	(	
			_									
			_		TOTAL (agree to Schedule V,		\$_	239,470		TOTAL (agree to	Sch. V,	§ 17,5
			_		line 22, col.8)					line 20, col		
TOTAL (agree to Schedule V	· · · · · ·		\$_	668,000	E. Schedule of Non-Cash Compe	nsation Paid			G. Schedu	ile of Travel and Sen	ıinar**	
(Attach a copy of any manage	ement service agreement)	)			to Owners or Employees							
C. Professional Services										Description		Amour
Vendor/Payee	Type			Amount	Description	Line#		Amount				
HDSI	Data Processing		\$	7,237			\$		Out-of-St	ate Travel		\$
FR&R	Accounting			10,613								
Wolf & Company	Accounting		_	4,975			_					
Personnel Planners	Unemployment (	Consulting	_	1,944			_		In-State T	ravel		
Adjusted Off Page 5	Legal Retainer		_	1,050			_					
			_				_					
			_	-			_					
			_	·		-	_		Seminar I	Expense		- 5
			_				_			ADO Management		
			-				. <u>-</u>		11100 1111			
			_				_		Entertein	ment Expense		
TOTAL (agree to Schedule V	line 19 column 3)		-		TOTAL		\$		Entertain	(agree to Sch.	<u>v</u> (	
(If total legal fees exceed \$250	, , , , , , , , , , , , , , , , , , ,	. )	\$	25,819	101mi		Ψ=		TOTAL	line 24, col.	,	s (
(11 total legal lees exceed \$250	ou attach copy of invoices	5.)	<u> </u>	25,819					IUIAL	iine 24, col. 3	3)	<u>,                                     </u>

\* Attach copy of IMRF notifications SEE ACCOUNTANTS' COMPILATION REPORT

\*\*See instructions.

Page 21

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3). (See instructions.)

	(See instructions.)												
	1	2	3	4	5	6	7	8	9	10	11	12	13
		Month & Year						Amount of	Expense Amor	tized Per Year			
	Improvement	Improvement	Total Cost	Useful									
	Type	Was Made		Life	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													1
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		ls		\$	\$	\$	\$	\$	\$	\$	\$	s

E 924			OF ILLINOIS	n (n'in'	01/01/04	Б. 1.	Page 23
	y Name & ID Number Sacred Heart Home Inc. ENERAL INFORMATION:	#	0013334	Report Period Beginning:	01/01/04	Ending:	12/31/04
		(12)	Have easts for all	summling and sampless which are of th	a truna that aan	ha hillad ta	
(1)	Are nursing employees (RN,LPN,NA) represented by a union?	(13)		supplies and services which are of the Public Aid, in addition to the daily r			
(2)	Are there any dues to nursing home associations included on the cost report?  No  If YES, give association name and amount.			ection of Schedule V?  N/A		erry classified	
(3)	Did the nursing home make political contributions or payments to a political action organization?  No  If YES, have these costs been properly adjusted out of the cost report?	(14)	the patient census is a portion of the	building used for any function other listed on page 2, Section B? No building used for rental, a pharmacy, explains how all related costs were al	, day care, etc.)	For exampl If YES, attac	e,
(4)	Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?  No  If YES, what is the capacity?	(15)	Indicate the cost o on Schedule V. related costs?		assified to emply meal income to the amount.	been offset ag	ainst
(5)	Have you properly capitalized all major repairs and equipment purchases?  What was the average life used for new equipment added during this period?  Yes  10 Years	(16)	Travel and Transp	ortation			
	what was the average me used for new equipment added during this period:	(10)		included for out-of-state travel?	No		
(6)	Indicate the total amount of both disposable and non-disposable diaper expense			complete explanation.	110		
(0)	and the location of this expense on Sch. V. \$ 2,072 Line 10-2			separate contract with the Departmen	t to provide me	edical transpor	tation for
	and the focusion of this expense on ben. 1.		residents?				
(7)	Have all costs reported on this form been determined using accounting procedures			this reporting period. \$			
( )	consistent with prior reports? Yes If NO, attach a complete explanation.		c. What percent of	all travel expense relates to transpor	tation of nurse	s and patients	? 100% ln 14
				age logs been maintained? N/A		•	-
(8)	Are you presently operating under a sale and leaseback arrangement?  No  If YES, give effective date of lease.		e. Are all vehicles times when not	stored at the nursing home during the in use?  N/A	e night and all	other	
	11 1 E.S., give effective date of lease.			commuting or other personal use of	autos been adii	isted	
(9)	Are you presently operating under a sublease agreement? YES X NO		out of the cost ro		autos occii uaje	astea	
(-)	12510			ity transport residents to and fr	om day trair	ning?	No
(10)	Was this home previously operated by a related party (as is defined in the instructions for			mount of income earned from p			
` '	Schedule VII)? YES NO X If YES, please indicate name of the facility,	,		n during this reporting period.	· .	\$	
	IDPH license number of this related party and the date the present owners took over.						_
		(17)		performed by an independent certific	ed public accor		No
			Firm Name:			The instruc	
(11)	Indicate the amount of the Provider Participation Fees paid and accrued to the Department			that a copy of this audit be included	with the cost re	eport. Has the	s copy
	of Public Aid during this cost report period. \$ 94,428  This amount is to be recorded on line 42 of Schedule V.		been attached?	If no, please explain.			
	This amount is to be recorded on line 42 of Schedule V.	(10)	Have all agets whi	ah da mat ralata ta tha mravisian af la	tamma aana h	an adivated	
(12)	Are there any salary costs which have been allocated to more than one line on Schedule V	(10)	out of Schedule V	ch do not relate to the provision of lo  Yes	ing term care o	een adjusted (	out
(12)	for an individual employee? No If YES, attach an explanation of the allocation.		out of Schedule v	! Tes			
	i i Eo, anach an explanation of the anocation.	(19)	If total legal fees a	are in excess of \$2500, have legal inv	oices and a sur	mmary of serv	ices
	SEE ACCOUNTANTS' COMPILATION REPORT	(1)		tached to this cost report? N/A	o.cos una a sur	01 301 v	
			1	d a summary of services for all archi	tect and apprai	isal fees.	